



CONTRACT AMENDMENT COVER SHEET

Agency Tracking # 31865-00600	Edison ID	Contract # 61494	Amendment # 1		
Contractor Legal Entity Name OptumRx Inc.			Edison Vendor ID 0000019398		
Amendment Purpose & Effect(s) Exercise Renewal Option, Increase Maximum Liability, Language Changes					
Amendment Changes Contract End Date: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		End Date: December 31, 2023			
TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A):			\$ 6,000,000.00		
Funding —					
FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2019	\$0.00	\$0.00			\$0.00
2020	\$3,628,200.00	\$3,621,800.00			\$7,250,000.00
2021	\$7,256,600.00	\$7,193,400.00			\$14,450,000.00
2022	\$7,256,600.00	\$7,193,400.00			\$14,450,000.00
2023	\$3,675,000.00	\$3,675,000.00			\$7,350,000.00
2024	\$3,000,000.00	\$3,000,000.00			\$6,000,000.00
TOTAL:	\$24,816,400.00	\$24,683,600.00			\$49,500,000.00
<p>Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.</p> <p style="font-size: 2em; font-weight: bold; margin-top: 20px;">Crystal G. Allen</p> <p style="font-size: 0.8em; margin-top: 10px;">Digitally signed by: Crystal G. Allen DN: CN = Crystal G. Allen email = Crystal.G.Allen@tn.gov C = US O = TennCare OU = Budget Date: 2022.11.16 15:10:45 -06'00'</p>			<p><i>CPO USE</i></p>		
Speed Chart (optional)		Account Code (optional)			

**AMENDMENT #1
OF CONTRACT 61494
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION, DIVISION OF TENNCARE
AND
OPTUMRX, INC.**

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

1. Contract sections B.1 and B.2 are deleted in their entirety and replaced with the following:

- B.1. This Contract shall be effective for the period beginning February 22, 2019 ("Effective Date") and ending December 31, 2023 ("Term"). The State shall have no obligation for goods delivered or services provided by the Contractor prior to the Effective Date.
- B.2. Renewal Options. This Contract may be renewed upon satisfactory completion of the Term. The State reserves the right to execute up to three (3) renewal options under the same terms and conditions for a period not to exceed twelve (12) months each by the State, at the State's sole option. In no event, however, shall the maximum Term, including all renewals or extensions, exceed a total of ninety-four (94) months.

2. Contract section C.1 is deleted in its entirety and replaced with the following:

- C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Forty-Nine Million Five Hundred Thousand Dollars and Zero Cents (\$49,500,000.00) ("Maximum Liability"). This Contract does not grant the Contractor any exclusive rights. The State does not guarantee that it will buy any minimum quantity of goods or services under this Contract. Subject to the terms and conditions of this Contract, the Contractor will only be paid for goods or services provided under this Contract after a purchase order is issued to Contractor by the State or as otherwise specified by this Contract.

3. The following is added as Contract section E.27.

- E.27. Additional lines, items, or options. At its sole discretion, the State may make written requests to the Contractor to add lines, items, or options that are needed and within the Scope but were not included in the original Contract. Such lines, items, or options will be added to the Contract through a Memorandum of Understanding ("MOU"), not an amendment.
 - a. After the Contractor receives a written request to add lines, items, or options, the Contractor shall have ten (10) business days to respond with a written proposal. The Contractor's written proposal shall include:
 - (1) The effect, if any, of adding the lines, items, or options on the other goods or services required under the Contract;
 - (2) Any pricing related to the new lines, items, or options;
 - (3) The expected effective date for the availability of the new lines, items, or options; and
 - (4) Any additional information requested by the State.

- b. The State may negotiate the terms of the Contractor's proposal by requesting revisions to the proposal.
- c. To indicate acceptance of a proposal, the State will sign it. The signed proposal shall constitute a MOU between the Parties, and the lines, items, or options shall be incorporated into the Contract as if set forth verbatim.
- d. Only after a MOU has been executed shall the Contractor perform or deliver the new lines, items, or options.

4. The following is added as Contract section E.28:


E.28. State Drug Utilization Data (SDUD). The Contractor warrants to the State that it is familiar with the new requirement for certification of State Drug Utilization Data (SDUD) set forth in CFR 42 §447.511(e) which requires states to be accountable for SDUD data integrity by directly certifying within the Medicaid Drug Programs (MDP) system the SDUD submitted to CMS within 60 days of the end of each quarter by the Contractor or its subcontractors. Accordingly, the Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against all claims, liabilities, losses, and causes of action to the extent they arise, accrue, or result from any errors in its reporting of the quarterly SDUD to CMS by the Contractor or its subcontractors. This includes the costs of responding to a government action related to the error and any fines, penalties, or damages paid by the State of Tennessee because of the error(s).

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 once all required approvals are obtained. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

OPTUMRX, INC.:


 Kathryn Carey (Dec 2, 2022 09:16 CST)

12/02/2022

SIGNATURE

DATE

Kathryn Carey

CFO

PRINTED NAME & TITLE OF SIGNATORY (above)

STATE OF TENNESSEE< DEPARTMENT OF FINANCE AND ADMINISTRATION, DIVISION OF TENNCARE:


 JIM BRYSON, COMMISSIONER

12/06/2022

DATE



CONTRACT

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

Begin Date February 22, 2019	End Date December 31, 2022	Agency Tracking # 31865-00600	Edison Record ID 61494
Contractor Legal Entity Name OptumRx Inc.			Edison Vendor ID 0000019398

Goods or Services Caption (one line only)
Pharmacy Benefits Manager (PBM)

Contractor <input checked="" type="checkbox"/> Contractor	CFDA #
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Funding —					
FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2019	\$0.00	\$0.00			\$0.00
2020	\$3,628,200.00	\$3,621,800.00			\$7,250,000.00
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2022	\$7,256,600.00	\$7,193,400.00			\$14,450,000.00
2023	\$3,628,200.00	\$3,721,800.00			\$7,350,000.00
TOTAL:	\$21,769,600.00	\$21,730,400.00			\$43,500,000.00

Contractor Ownership Characteristics:

Minority Business Enterprise (MBE):
 African American Asian American Hispanic American Native American

Woman Business Enterprise (WBE)

Tennessee Service Disabled Veteran Enterprise (SDVBE)

Disabled Owned Business (DSBE)

Tennessee Small Business Enterprise (SBE): \$10,000,000.00 averaged over a three (3) year period or employs no more than ninety-nine (99) employees.

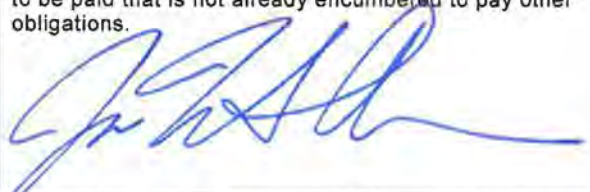
Government Non-Minority/Disadvantaged Other:

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

Competitive Selection Competitively Procured through PBM RFP 31865-00600

Other

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)
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**CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
DIVISION OF TENNCARE
AND
OPTUMRx, INC.**

This Contract, by and between the State of Tennessee, Department of Finance and Administration, Division of TennCare (TennCare), hereinafter referred to as the "State" or "TennCare" and OptumRx, Inc. ("Contractor"), hereinafter referred to as the "Contractor" or "PBM", is for the provision of Pharmacy Benefits Management (PBM) services for the State's TennCare Program, CoverRx Program, CoverKids Program, and Optional Program(s), as further defined in the "SCOPE OF SERVICES."

The Contractor is: For-Profit Corporation
Contractor Place of Incorporation or Organization: California
Contractor Edison Registration ID # 0000019398

A. SCOPE

- A.1. The Contractor shall provide all goods or services and deliverables as required, described, and detailed below and shall meet all service and delivery timelines as specified by this Contract. Applicable terms related to this contract are located in Attachment A.
- A.2. Contractor Required to Comply with the Centers for Medicare and Medicaid Services (CMS) Managed Care Rule, Identification of State Pharmacy Benefit Management (PBM) Programs, Non-Delegable State Duties. The Contractor shall provide all services required herein for the TennCare and CoverKids Programs, identified below, in compliance with applicable provisions of the CMS final Managed Care Rule (CMS Managed Care Rule) set forth in 42 C.F.R. §§ 431, 433, 438, 440, 455, 457, 496, *et seq.*, and all other applicable State and federal statutes, rules and requirements. CMS has determined that the Reconsideration phase of TennCare's existing TennCare appeal process satisfies the part 438 requirement for a Contractor-level appeal process. Accordingly, enrollees will not be required to exhaust an appeal with the Contractor before requesting a TennCare appeal. The Contractor shall use its network of pharmacy providers (Providers) and a point of sale (POS) adjudication system (Contractor's PBM System) adapted to meet the requirements of the TennCare, CoverRx and CoverKids PBM Programs set forth herein to provide required services to these PBM Programs. TennCare administers the health care programs identified below in the State of Tennessee, each of which provides certain pharmacy benefits for its enrollees, hereinafter variously referred to as "enrollees", "members", "recipients" or "participants". These programs are collectively referred to herein as the "TennCare PBM Programs" and are identified as follows:
- A.2.a. TennCare Program (TennCare): The federal Medicaid program, known as "TennCare" in Tennessee, is operated by the State pursuant to a waiver from the CMS. Nothing in this Contract shall be deemed to be a delegation to the Contractor of the State's non-delegable duties relating to TennCare, as administered by the single state agency designated by the State and CMS, pursuant to Title XIX of the Social Security Act (42 U.S.C § 1396 *et seq.*) and the Section 1115 research and demonstration waiver granted to the State and any successor programs. TennCare services shall be provided through a statewide TennCare Program pharmacy provider network (TennCare Provider Network) established and maintained by Contractor that supports the following PBM provider types: Ambulatory, 340B, Specialty, and Long Term Care (LTC) pharmacies, along with Physician Dispensaries. The TennCare Provider Network shall comply with applicable law as referenced in section A.2.
- A.2.b. CoverRx Program (CoverRx): The State's pharmacy assistance program, hereinafter referred to as "CoverRx", provides limited pharmacy assistance through retail or mail order to eligible participants enrolled in the State's Department of Mental Health and Substance Abuse Services Safety Net program and for other eligible adults ages nineteen (19) through sixty-

four (64) needing access to prescription drugs for acute care and ongoing disease management. CoverRx is not a prescription drug benefit, an insurance program, nor an entitlement program. It is paid for by State funds, without any federal funds participation, and has two distinct parts: (1) a Covered Drug List (CDL), and (2) a Drug Discount List.

- A.2.c. CoverKids Program (CoverKids): The federal Social Security Act Title XXI Children's Health Insurance Program (CHIP), known as "CoverKids" in Tennessee, provides self-funded health plan services, including certain pharmacy benefits, to eligible children under age nineteen (19), including unborn children who are covered from conception to birth. The Contractor's responsibilities for the CoverKids Program under this Contract are limited to providing PBM and related services as set forth herein. CoverKids services shall be provided by the Contractor through its commercial program established and operated by the Contractor utilizing its national pharmacy provider network, national drug formulary, national claims processing staff, national rebate programs, mail order program and its various commercial enrollee and Provider support systems. Such support systems shall include, but are not limited to, Contractor's national prior authorization (PA) unit, Help Desk services for both enrollees and Providers, and Contractor's internal grievance and appeal resolution system that complies with 42 C.F.R. § 457.1260 to handle enrollee appeals for the CoverKids PBM Program. The Contractor's national provider network shall be capable of providing ambulatory and specialty PBM services to CoverKids enrollees.
- A.2.d. Optional CoverKids Services (Optional CoverKids Services): The State may, at its option, (a) request that the Contractor use TennCare's CoverKids Preferred Drug List (PDL), rather than the Contractor's national formulary, and/or (b) provide Medication Therapy Management (MTM) services to CoverKids enrollees. If the State exercises either or both of these options, the parties shall effect the Optional CoverKids Services through amendment(s) to this Contract negotiated between the State and Contractor setting forth the Scope of Services, compensation to be paid to the Contractor for each Optional CoverKids Service, and any related extensions of the term of this Contract. The State has sole discretion in determining whether or not to request such Optional CoverKids Services and whether the Contractor's proposed terms for providing such Optional CoverKids Services are acceptable to the State. The State's decision on this matter shall not be subject to appeal by the Contractor.
- A.2.e. Optional PBM Program Services (Optional Services): At the option of the State, the Contractor may be requested to provide PBM services to the State for one (1) or more additional State programs. If the State exercises this option, the parties shall effect the Optional Services for such additional population(s) through amendment(s) to this Contract negotiated between the State and Contractor setting forth the Scope of Services, compensation to be paid to the Contractor for each Optional Service, and any related extensions of the term of this Contract. The State has sole discretion in determining whether or not to request such Optional Services and whether the Contractor's proposed terms for providing such Optional Services are acceptable to the State. The State's decision on this matter shall not be subject to appeal by Contractor.
- A.3. Contractor Duties and Requirements Applicable to All TennCare PBM Programs, General Contract Provisions, Contractor Deliverables. The Scope of Services contains general Contractor requirements, deliverables and provisions applicable to all TennCare PBM Programs, as well as requirements, deliverables and provisions applicable only to a specific program. TennCare and the Contractor hereby confirm that there are no known conflicts that prevent the Contractor from sharing the resources required herein among all of the TennCare PBM Programs. Such resources include, but are not limited to, Contractor's Staff and Providers and its computer and data storage systems. In the event a conflict occurs that prevents continued sharing of these resources, the State will notify the Contractor through the Control Memorandum process set forth in Section A.5 below of the conflict and provide instructions to the Contractor relating to how the conflict will be handled. Unless otherwise indicated, the requirements, deliverables, Contractor resources, and provisions contained herein shall be deemed to be applicable to all TennCare PBM Programs.

The descriptions of Contractor deliverables in this Contract do not include every possible duty, task, or intermediate deliverable necessary to achieve success on this Contract. The Contractor understands and agrees that any perceived lack of detail in a specific area does not indicate that the Contractor will have no duties in that area. The Contractor shall fulfill the State's Contract goals and requirements in a cost-effective manner. This includes all intermediate steps, deliverables or processes reasonably necessary to achieve the desired outcome described in each section of the Contract. Intermediate steps, processes or deliverables may, at the State's discretion, be described in greater detail in a Control Memorandum, developed by the parties using the Control Memorandum process described below. Many objectives described here only describe the end result, thus allowing Contractor flexibility in proposing the details of how their solution meets the State's goals.

- A.4. Contractor's Coordination, Collaboration and Non-Disclosure Responsibilities. The Contractor shall, as directed by the State and at no additional cost to the State, coordinate with, facilitate the prompt exchange of information between, and work collaboratively with any and all other State contractors and State agencies. If required in order for the Contractor to proceed with any part of the Scope of Services which involves sharing or obtaining information of a confidential, proprietary, or otherwise valuable nature with or from another State contractor or State agency, the Contractor may be requested to sign mutually agreeable documents, including but not limited to Non-Disclosure Agreements (Non-Disclosure Documents), which are reasonably necessary to maintain cooperation and collaboration among and with any and all other State contractors and State agencies in the performance of the Contract.

All information the Contractor may receive, have disclosed to it, or otherwise becomes known to Contractor during the performance of this Contract from any other State contractor or State agency, that the State contractor or State agency considers to be propriety or confidential in nature pursuant to a Non-Disclosure Document entered into between the Contractor and another State contractor or State agency, shall be governed by such Non-Disclosure Document, except that the State and other federal and State agencies or authorities, as allowed by law, are entitled to any information related to the performance of this Contract, including information that would otherwise be deemed proprietary. Such information once disclosed to the State will still be deemed confidential pursuant to the protections provided by T.C.A. §71-5-142.

Nothing in this Section, including failure to negotiate and enter into a Non-Disclosure Document acceptable to the Contractor with another State contractor or State agency, shall be construed to relieve the Contractor of its duty to perform any requirements or deliverables under this Contract. Other than as permitted throughout Section C of this Contract, Payment Terms and Conditions, the Contractor shall not invoice the State for any such coordination services, and the State shall not be liable to the Contractor for payment of any such coordination services, without the prior written consent of the State.

- A.5. Control Memorandum Process. The Control Memorandum ("CM") process shall be utilized by the State to clarify Contract requirements, issue instruction to the Contractor, document action required of the Contractor, or request information from the Contractor. In addition, the CM process shall be used by the State to impose assessments of damages, either Actual or Liquidated. This process will be used to address issues or matters that do not require a contract amendment. Each CM must be in writing and indicate the date on which it was issued. CMs may provide relevant history, background, and other pertinent information regarding the issue(s) being addressed in the CM. Each CM will establish a deadline or timeframe for the Contractor's reply or other action. All CMs submitted to the Contractor must be signed and approved by the State's Project Director (or his/her designee). When the CM pertains to damages, either Actual or Liquidated, the State may issue consecutive CMs, as may be necessary or appropriate.

- A.5.a. A CM may include one (1) or more of the following five (5) components of the CM process described below:

1. On Request Report (ORR) – a request directing the Contractor to provide information by the time and date set out in the CM.

2. Control Directive (CD) – instructions that require the Contractor to complete, within a designated timeframe, one (1) or more deliverables or to perform any other request from the State that is within the scope of the Contract. A CD may also provide clarification of certain Contract terms. Once a CM/CD has been issued, it shall be considered to be incorporated into this Contract.
 3. Notice of Potential Damages (Actual or Liquidated) (NPD) – notification to the Contractor that the State has determined that a potential Contract performance or compliance failure exists and that the State is contemplating assessing damages, Actual and/or Liquidated. The NPD shall identify the Contract provision(s) on which the State determination rests.
 4. Notice of Calculation of Potential Damages (Actual or Liquidated) (NCPD) – notification to the Contractor that provides a calculation of the amount of potential damages, Actual and/or Liquidated, that the State is contemplating assessing against the Contractor. NPDs and NCPDs may be issued consecutively or simultaneously.
 5. Notice of Intent to Assess Damages (Actual or Liquidated) (NIAD) – notification to the Contractor that the State is assessing damages and specifying whether the damages are Actual Damages, Liquidated Damages, or both, and setting out the performance or compliance failure underlying each intended damage assessment. The NIAD shall identify the NPD and NCPD upon which it is based. The NIAD shall specify the total amount and type of damages, whether Actual or Liquidated, the State intends to assess. Following the issuance of an NIAD, the State may elect to withhold damages from payments due to Contractor. The State may not issue a NIAD without first issuing a NPD and a NCPD. The State may not obtain both Liquidated Damages and Actual Damages for the same occurrence of a Contract performance or compliance failure.
- A.5.b. Damages for failure to comply with CM. The Contractor shall fully comply with all CMs. Failure to do so may result in the State pursuing recovery of damages, as defined in Section E.10, including Liquidated Damages as listed in Contract Attachment C, a corrective action plan, and/or termination of the Contract.
- A.5.c. Appeal of Damages by Contractor. Contractor may appeal either the basis for NPD or calculation of NCPD potential damages, either Actual or Liquidated. To do so, the Contractor shall submit to the State's Project Director (or his/her designee) a written response to the NPD and/or NCPD within ten (10) business days of receipt of a CM which includes a NPD or a NCPD. The State's Project Director (or his/her designee) shall review the appeal and provide notice of his/her determination to the Contractor through a CM. If the Contractor disagrees with the State's Project Director's (or his/her designee) initial appeal determination or the State's Project Director (or his/her designee) is unable to resolve the appeal, the Contractor may submit a written request to the State's Project Director (or his/her designee) that the matter be escalated to senior management of the Agency. Contractor shall submit such a request for escalation within ten (10) business days of its receipt of the initial appeal determination from the State's Project Director (or his/her designee) or of notification by the State's Project Director that he/she is unable to resolve the appeal. The State's senior management shall provide written notice of its final determination to the Contractor within (10) days of the receipt of the appeal from the Contractor. Upon appeal or escalation, the State shall not increase the amount of the potential damages.
- A.6. Nondiscrimination Compliance Requirements. The Contractor shall comply with all applicable federal and state civil rights laws, regulations, rules, and policies and Contract Section D.9 of this Contract.
- A.6.a. In order to demonstrate compliance with the applicable federal and State civil rights laws and regulations, which may include, but are not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 (regarding

education programs and activities), Section 1557 of the Patient Protection and Affordable Care Act (ACA) (codified at 45 C.F.R. pt. 92) the Contractor shall designate a staff person to be responsible for nondiscrimination compliance.

The Contractor's Nondiscrimination Compliance Coordinator ("NCC") shall be responsible for compliance with the nondiscrimination requirements set forth in this Contract. Contractor agrees that its civil rights compliance staff member will work directly with TennCare's Civil Rights Compliance Director in order to implement and coordinate nondiscrimination compliance activities. The Contractor does not have to require that civil rights compliance be the sole function of the designated NCC staff member. However, the Contractor shall identify the designated NCC staff member to TennCare by name.

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

1. The Contractor's NCC shall develop a nondiscrimination training plan within thirty (30) days of the Effective Date of this Contract and shall provide a copy of such training plan to TennCare on an annual basis and upon request. If needed, the NCC may request an extension of time for this due date. Thereafter, this training plan shall be updated as needed to conform to changes in Federal and State law and provided to TennCare as set forth above.

On an annual basis, the NCC shall be responsible for making nondiscrimination training available to all Contractor staff and to its subcontractors that are considered to be recipients of federal financial assistance under this contract. The Contractor shall be able to show documented proof that the training was made available to the Contractor's staff and to its subcontractors that are considered to be recipients of federal financial assistance under this contract.

2. The Contractor shall, at a minimum, emphasize nondiscrimination in its personnel policies and procedures as it relates to hiring, promoting, operational policies, contracting processes and participation on advisory/planning boards or committees.
3. Prior to implementation of this Contract, the Contractor shall provide its written policies and procedures that demonstrate nondiscrimination in the provision of services provided under this Contract to TennCare. These policies shall include topics, such as, the provision of language services to individuals with Limited English Proficiency and individuals requiring communication assistance in alternative formats and providing other forms of assistance to individuals with disabilities. Effective Communication may be achieved by providing interpretation and translation services and other forms of auxiliary aids or services, including, Braille and large print and shall be based on the needs of the individual and/or the individual's representative. These nondiscrimination policies and procedures shall be approved in writing by TennCare prior to the Go Live date of any TennCare PBM Program.
4. The Contractor shall keep such records as may be necessary in order to submit timely, complete and accurate compliance reports that may be requested by the U.S. Department of Health and Human Services ("HHS"), the U.S. Department of Justice ("DOJ"), TennCare, and the Tennessee Human Rights Commission ("THRC") or their designees. If requested, the information shall be provided in a format and timeframe specified by HHS, DOJ, TennCare, or THRC. The requested information may be necessary to enable HHS, DOJ, TennCare, or THRC to ascertain whether the Contractor is complying with the applicable civil rights laws. For example, the Contractor should have available data showing the manner in which services are or

will be provided by the program in question, and related data necessary for determining whether any persons are or will be denied such services on the basis of prohibited discrimination. Further examples of data that could be requested can be found at 45 C.F.R. § 80.6 and 28 C.F.R. § 42.406.

5. The Contractor shall permit access as set forth in the applicable civil rights laws, such as, 45 C.F.R. § 80.6 to HHS, DOJ, TennCare, and THRC or their designees during Working Hours to such of its books, records, accounts, and other sources of information, and its facilities as may be pertinent to ascertain whether the Contractor is complying with the applicable civil rights laws.
6. The Contractor shall use and have available to individuals TennCare's discrimination complaint forms for the TennCare program or programs covered under this contract. These discrimination complaint forms shall be provided to individuals upon request and be available on the Contractor's website. TennCare's discrimination complaint forms are vital documents and must be available at a minimum in the English, Arabic, and Spanish languages. TennCare's Director of Civil Rights Compliance shall work with the Contractor's NCC on providing the Contractor with the TennCare programs or programs' discrimination complaint forms that are required under this contract.

The Contractor shall provide assistance to individuals that request that the Contractor assist them with filing discrimination complaints with the TennCare program or programs covered under this contract. The Contractor shall inform its employees and its Providers and subcontractors that are considered to be recipients of federal financial assistance under this contract about how to assist individuals with obtaining discrimination complaint forms and assistance with submitting the forms to the TennCare program or programs covered under this contract.

7. Significant publications and significant communications, including small sized publications and communications that are targeted to beneficiaries, participants, enrollees, applicants, and members of the public shall be printed with the notice of nondiscrimination and LEP taglines as required by TennCare and set forth in TennCare's tagline templates. Written materials specific to TennCare's programs' members shall be prior approved in writing by TennCare prior to the materials being sent to these individuals.
8. Within ninety (90) calendar days of notification from TennCare, all vital Contractor documents related to this Contract shall be translated and available to each Limited English Proficiency ("LEP") group identified by TennCare in accordance with the applicable standards set forth below:
 - (a) If a LEP group constitutes five percent (5%) or 1,000 enrollees, whichever is less, of the population targeted under this Contract, vital documents shall be translated into that LEP language. Translation of other documents, if needed, can be provided orally; or
 - (b) If there are fewer than fifty (50) individuals in a language group that is part the population targeted under this Contract that reaches the five percent (5%) trigger in (a), the Contractor shall inform those individuals that it does not provide written translation of vital documents but provides written notice in that group's primary language of the right to receive competent oral interpretation of those written materials, free of cost.
 - (c) At a minimum, all vital Contractor documents shall be translated and available in Spanish.
9. In accordance with the requirements set forth in 42 U.S.C. § 300kk, the Contractor must develop and maintain the ability to collect and report data on race, ethnicity, sex, age, primary language, and disability status for the population targeted under

this Contract and the parents or legal guardians of minors or legally incapacitated individuals targeted under this Contract. In collecting this data the Contractor shall use the Office of Management and Budget (OMB) standards, at a minimum, for race and ethnicity measures. Data collection standards for Race, Ethnicity, Sex, Primary Language, and Disability Status are available from the Office of Minority Health and on its website located at:

<https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=23>

- A.6.b. The Contractor shall submit the following nondiscrimination compliance deliverables to TennCare as follows:
1. Annually, TennCare shall provide the Contractor with a Nondiscrimination Compliance Questionnaire. The Contractor shall answer the questions contained in the Compliance Questionnaire and submit the completed Questionnaire to TennCare within sixty (60) calendar days of receipt of the Questionnaire with any requested documentation, which shall include, the Contractor's Assurance of Nondiscrimination. The signature date of the Contractor's Nondiscrimination Compliance Questionnaire shall be the same as the signature date of the Contractor's Assurance of Nondiscrimination. The Nondiscrimination Compliance Questionnaire deliverables shall be in a format specified by TennCare.
 - (a) As part of the requested documentation for the Nondiscrimination Compliance Questionnaire, the Contractor shall submit copies of its nondiscrimination policies and procedures that demonstrate nondiscrimination in the provision of its services, programs, or activities provided under this Contract. These policies shall include topics, such as, the provision of language assistance services for LEP individuals and those requiring effective communication assistance in alternative formats, and providing assistance to individuals with disabilities. Any nondiscrimination policies and procedures that are specific to TennCare program members shall be prior approved in writing by TennCare.
 - (b) Also as part of the requested documentation for the Nondiscrimination Compliance Questionnaire the Contractor shall include reports that capture data for all language and communication assistance services used and provided by the Contractor under this Contract. One report shall contain the names of the Contractor's language and communication assistance service providers, the languages that interpretation and translation services are available in, the auxiliary aids or services that were provided and that are available, the hours the language assistance services are available, and the numbers individuals call to access language and communication assistance services. A separate report that captures a listing of language and communication assistance services that were requested by members (i.e. Arabic; Braille) and the methods used to provide the language and alternative communication service to the members (i.e. interpretation; translation). Upon request the Contractor shall provide a more detailed report that contains the requestor's name and identification number, the requested service, the date of the request, the date the service was provided, and the name of the service provider.
 2. The Contractor shall submit a quarterly Non-discrimination Compliance Report which shall include the following:
 - (a) A summary listing that captures the total number of the Contractor's new hires that have completed civil rights/nondiscrimination training and cultural competency training and the dates the trainings were completed for that quarter;

- (b) A listing of the total number of the Contractor's employees that have completed annual civil rights training and cultural competency training and the dates completed for that quarter, if annual training was provided during that quarter.
- (c) An update of all written discrimination complaints filed by individuals, such as, employees, members, and subcontractors in which the discrimination allegation is related to the provision of and/or access to TennCare covered services provided by the Contractor, which the Contractor is assisting TennCare with resolving. This update shall include, at a minimum: identity of the complainant, complainant's relationship to the Contractor, circumstances of the complaint; type of covered service related to the complaint, date complaint filed, the Contractor's resolution, date of resolution, and the name of the Contractor staff person responsible for adjudication of the complaint. For each complaint reported as resolved the Contractor shall submit a copy of the complainant's letter of resolution.
- (d) The Contractor shall provide a listing of all discrimination claims that are reported to the Contractor that are claimed to be related to the provision of and/or access to TennCare covered services provided by the Contractor. The listing shall include, at a minimum: identity of the complainant, complainant's relationship to the Contractor, circumstances of the complaint; type of covered service related to the complaint, date complaint filed, the Contractor's resolution, date of resolution. When such reports are made, the Contractor shall offer to provide the discrimination complaint forms to the individual making the report.
- (e) The language and communication assistance report shall capture a summary listing of language and communication assistance services that were requested by members (i.e. Arabic; Braille) and the methods used to provide the language and alternative communication service to the members (i.e. interpretation; translation). Upon request the Contractor shall provide a more detailed report that contains the requestor's name and identification number, the requested service, the date of the request, the date the service was provided, and the name of the service provider.

A.6.c. Discrimination Complaint Investigations. All discrimination complaints against the Contractor and its employees and its subcontractors that are considered to be recipients of federal financial assistance under this contract shall be resolved according to the provisions of this Section and the below subsections:

1. Discrimination Complaints against the Contractor and/or Contractor's Employees. When complaints concerning alleged acts of discrimination committed by the Contractor and/or its employees related to the provision of and/or access to one of TennCare's programs are reported to the Contractor, the Contractor's NCC shall send such complaints within two (2) business days of receipt to TennCare. TennCare shall investigate and resolve all alleged acts of discrimination committed by the Contractor and/or its employees. The Contractor shall cooperate with TennCare during the investigation and resolution of such complaints. TennCare reserves the right to request that the Contractor's NCC assist with conducting the initial investigations and to suggest resolutions of alleged discrimination complaints. If TennCare requests that the Contractor's NCC assist TennCare with conducting the initial investigation, the Contractor's NCC, within five (5) business days from the date of the request, shall start the initial investigation. The Contractor's NCC shall provide TennCare with all requested information, including but not limited to, the identity of the party filing the complaint; the complainant's relationship to the Contractor; the circumstances of the complaint; date complaint filed; and the Contractor's suggested resolution. TennCare shall review the Contractor's initial investigations and determine the appropriate resolutions for the complaints as set forth in subsection 2

below. During the complaint investigation, the Contractor shall have the opportunity to provide TennCare with any information that is relevant to the complaint investigation. Any documentation or materials related to such investigation shall be considered confidential and not subject to disclosure to any third party, unless disclosure is otherwise required by law.

2. **Discrimination Complaints against the Contractor's Subcontractors** that are recipients of federal financial assistance under this Contract. Should complaints concerning alleged acts of discrimination committed by the Contractor's subcontractors related to the provision of and/or access to one of TennCare's programs be reported to the Contractor, the Contractor's nondiscrimination compliance officer shall inform TennCare of such complaints within two (2) business days from the date Contractor learns of such complaints. If TennCare requests that the Contractor's nondiscrimination compliance officer assist TennCare with conducting the initial investigation, the Contractor's nondiscrimination compliance officer within five (5) business days from the date of the request shall start the initial investigation. Once an initial investigation has been completed, the Contractor's nondiscrimination compliance officer shall report his/her determinations to TennCare. At a minimum, the Contractor's nondiscrimination compliance officer's report shall include the identity of the party filing the complaint; the complainant's relationship to the Contractor; the circumstances of the complaint; date complaint filed; and the Contractor's suggested resolution. TennCare shall review the Contractor's initial investigations and determine the appropriate resolutions for the complaints as set forth in subsection (3) below. TennCare reserves the right to investigate and resolve all complaints concerning alleged acts of discrimination committed by the Contractor's subcontractors that are recipients of federal financial assistance under this Contract. The Contractor's Providers and Subcontractors that are recipients of federal financial assistance under this Contract shall cooperate with TennCare and the Contractor during discrimination investigations and resolutions.
3. **Corrective Action Plans to Resolve Discrimination Complaints.** If a discrimination complaint against the Contractor or its employees or one of its subcontractors who are recipients of federal financial assistance under this contract, is determined by TennCare to be valid, TennCare shall, at its option, either (i) provide the Contractor with a corrective action plan to resolve the complaint, or (ii) request that the Contractor submit a proposed corrective action plan to TennCare for review and approval that specifies what actions the Contractor proposes to take to resolve the discrimination complaint. Upon provision of the corrective action plan to Contractor by TennCare, or approval of the Contractor's proposed corrective action plan by TennCare, the Contractor shall implement the approved corrective action plan to resolve the discrimination complaint. TennCare, in its sole discretion, shall determine when a satisfactory discrimination complaint resolution has been reached and shall notify Contractor of the approved resolution. A discrimination complaint resolution corrective action plan may consist of approved nondiscrimination training on relevant discrimination topics. Prior to use, the nondiscrimination training material shall be reviewed and approved by TennCare. Time periods for the implementation of the corrective action plan nondiscrimination training shall be designated by TennCare.

A.6.d. **Electronic and Information Technology Accessibility Requirements.** To the extent that the Contractor is using electronic and information technology to fulfill its obligations under this Contract, the Contractor agrees to comply with the electronic and information technology accessibility requirements under the federal civil rights laws including Section 504 and Section 508 of the Rehabilitation Act of 1973 ("Section 508"), the Americans with Disabilities Act, and 45 C.F.R. pt. 92. To comply with the accessibility requirements for Web content and non-Web electronic documents and software, the Contractor shall use W3C's Web Content Accessibility Guidelines ("WCAG") 2.0 AA (For the W3C's guidelines see: <http://www.w3.org/TR/WCAG20/>) (Two core linked resources are Understanding WCAG 2.0 <http://www.w3.org/TR/UNDERSTANDING-WCAG20/> and Techniques for WCAG 2.0 <http://www.w3.org/TR/WCAG20-TECHS/>).

Contractor agrees to perform regularly scheduled (i.e., automatic) scans and manual testing for WCAG 2.0 AA compliance for all user content and applications in order to meet the standards for compliance. The Contractor must ensure that any system additions, updates, changes or modifications comply with WCAG 2.0 AA. Commercial Off-the-shelf ("COTS") products may be used to verify aspects of WCAG 2.0 AA compliance.

Additionally, the Contractor agrees to comply with Title VI of the Civil Rights Act of 1964. In order to achieve Title VI compliance the Contractor should add a system function that allows users to translate the content into a language other than English. This requirement may be satisfied by the provision of a link to Google translate or other machine translate tool.

Should the system or a component of the system fail to comply with the accessibility standards, the Contractor shall develop and submit to TennCare for approval a noncompliance report that identifies the areas of noncompliance, a plan to bring the system or component into compliance, an alternative/work around that provides users with the equivalent access to the content, and a timeframe for achieving that compliance. TennCare shall review the noncompliance report to determine whether or not it is acceptable and should be implemented. Once the noncompliance report is approved by TennCare the Contractor may implement the compliance plan. TennCare, in its sole discretion, shall determine when a satisfactory compliance plan resolution has been reached and shall notify the Contractor of the approved resolution. If Contractor is unable to obtain content that conforms to WCAG 2.0 AA, it shall demonstrate through its reporting to TennCare that obtaining or providing accessible content would fundamentally alter the nature of its goods and services or would result in an undue burden.

A.6.e. Health Disparities Strategy. The Contractor shall participate in TennCare's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status.

A.6.f. Enrollee/Member Enrollment, Disenrollment, Re-enrollment.

1. The Contractor shall accept enrollees in the order in which applications are approved and enrollees are assigned to the Contractor (whether by selection or assignment). The Contractor shall not use any policy or practice that has the effect of discriminating against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability.
2. The Contractor shall accept an enrollee in the health condition the enrollee is in at the time of enrollment and shall not discriminate against individuals on the basis of health status, the need for health care services, or on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability.

A.6.g. Provider Participation, Reimbursement, or Indemnification.

1. The Contractor shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. The Contractor's ability to credential providers as well as maintain a separate network and not include any willing provider is not considered. The Contractor's written policies and procedures for the selection and retention of providers shall not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment;
2. The Contractor shall not discriminate against providers and entities in accordance with the federal prohibition against discrimination as provided for under the collective "federal health care provider conscience protection statutes," referenced individually as the Church Amendments, 42 U.S.C. § 300a-7, section 245 of the Public Health Service Act, 42 U.S.C. § 238n, and the Weldon Amendment, Consolidated

Appropriations Act, 2010, Public Law 111–117, Div. D, Sec. 508(d), 123 Stat. 3034, 3279–80.

A.6.h. Moral/Ethical or/and Religious Directives.

1. Should the Contractor not cover a TennCare covered service because of moral/ethical or religious reasons, the Contractor shall provide a list of these services to TennCare. This list shall be used by TennCare to provide information to TennCare members about where and how the members can obtain the services that are not being delivered due to Ethical and Religious Directives.
2. Should the Contractor contract with providers and/or subcontractors to deliver services to TennCare members pursuant to the Contractor's obligations under this Contract and the providers or subcontractors cannot provide a TennCare covered service because of moral/ethical or religious reasons, the Contractor shall provide a list of these services to TennCare. This list shall be used by the Contractor and TennCare to provide information to TennCare members about where and how the members can obtain the services that are not being delivered due to Ethical and Religious Directives.
3. For Provider Agreements that include Moral/Ethical or/and Religious Directives provisions, include the following requirements:
 - (a) The Provider shall provide a list of the services it does not deliver due to the Moral/Ethical and Religious Directives to the Contractor. The Contractor shall furnish this list to TennCare, notating those services that are TennCare covered services. This list shall be used by the Contractor and TennCare to provide information to TennCare members about where and how the members can obtain the services that are not being delivered by the Provider due to Moral/Ethical and Religious Directives.
 - (b) At the time of service, the Provider shall inform TennCare members of the healthcare options that are available to TennCare members, but are not being provided by the Provider due to the Moral/Ethical and Religious Directives, but the Provider is not required to make specific recommendations or referrals. In addition, the Provider shall inform TennCare members that the Contractor has additional information on providers and procedures that are covered by TennCare.

A.6.i. Culturally Competent Delivery of TennCare PBM Program Services. The Contractor shall and its Providers and Subcontractors that are providing TennCare PBM Program services pursuant to this Contract shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency, disabilities and diverse cultural and ethnic backgrounds regardless of an enrollee's gender, sexual orientation, or gender identity. This includes the Contractor emphasizing the importance of network providers to have the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing of services to enrollees with physical or mental disabilities.

A.7. TennCare PBM Program Services Staffing. The Contractor may use a combination of employees and subcontractors to perform the services required in this Contract. Unless otherwise indicated, the term "Staff" shall be deemed to include Contractor's employees, Key Staff, supervisory staff, support staff, and subcontractors (regardless of what function the subcontractors perform). Unless otherwise indicated, the term "On Site" shall be deemed to mean the indicated Contractor's Staff shall be assigned to either (1) work at the TennCare offices in Nashville, Tennessee, or (2) work at a specified work location other than the TennCare offices, as his/her assigned work location, and he/she shall be expected to perform one hundred percent (100%) of his/her assigned duties from that location, unless authorized in writing by the State to work at a different location.

The Contractor shall maintain sufficient levels of Staff who have appropriate training, work experience, and expertise to perform all Contract requirements and provide all services and deliverables in a timely and satisfactory manner. General staffing requirements for this Contract are set forth below, followed by specific staffing requirements for the TennCare, CoverRx and CoverKids PBM Programs. Subject to the provisions set forth herein, the Contractor shall have total responsibility for hiring and management of all Staff determined necessary to perform the services in accordance with the terms of this Contract.

A.7.a. General Staffing Requirements

1. Staffing Plans. The Contractor shall provide proposed TennCare, CoverRx and CoverKids Program staffing plans (Staffing Plans) for review and approval by TennCare in accordance with the Implementation Schedule for each TennCare PBM Program set forth below. The Staffing Plans shall include, at a minimum, the TennCare PBM Programs Key Staff (Key Staff) positions identified below and any necessary supervisory and support Staff. The Staffing Plans shall also include the proposed work location, work schedule, and reporting structure for all Staff. At the time the Staffing Plans are submitted to TennCare, the Contractor shall also provide copies of resumes and job descriptions (if not already included in the Contract) for all Staff assigned to this Contract. The Contractor shall provide TennCare with a revised Staffing Plan within three (3) business days of any Staff change.
2. Staff Licensing and Certification Requirements. The Contractor shall provide TennCare with documentation verifying that all Staff are licensed to practice in his/her area of specialty. This documentation shall be supplied to the State prior to Go-Live for each of the TennCare PBM Programs, and annually thereafter, as directed in writing by TennCare.
3. Staff Knowledge and Expertise. The Contractor shall provide Staff that are current and knowledgeable in their respective areas of expertise and are able to provide quality consultation and technical assistance services regarding all matters pertaining to pharmacy benefits. The Contractor shall also ensure that all Staff are trained and knowledgeable regarding all applicable aspects of each TennCare PBM Program.
4. Staff Training. A Staff Training Plan (Training Plan) shall be submitted to TennCare for approval within ten (10) business days of the Effective Date of this Contract. Contractor shall prepare all Staff training materials (Training Materials) and submit them to TennCare, pursuant to the TennCare PBM Program Implementation Plans, for review and approval prior to beginning Staff training. The Contractor shall be responsible for providing training to all Staff prior to those individuals performing any TennCare PBM Program services. All Staff shall receive annual refresher training covering their job responsibilities. TennCare reserves the right, at any time during the term of this Contract, to require the Contractor to provide remedial training to specific Staff members or groups of Staff members, if their performance indicates such training is needed.
5. Subcontracting. In addition to the requirements regarding subcontracting set forth elsewhere in this Contract, the Contractor shall be required, upon written request from the State, to provide a complete, signed copy of any subcontracts it currently has with any third party who performs services under this Contract. Such subcontracts shall be provided within five (5) business days of receipt of the State's request. The subcontracts may be redacted only to the extent necessary to conceal the amount of compensation paid by the Contractor to its subcontractors.

Subcontractors identified in Contractor's response to the RFP associated with this Contract that were previously approved by the State are deemed to be approved subcontractors. Contractor may only substitute an approved subcontractor or add a new subcontractor at the discretion of the State, and with the State's prior written

approval after review of the proposed subcontract. All subcontract agreements entered into by the Contractor for the provision of TennCare PBM Program services shall require the subcontractor to comply with all applicable provisions of this Contract. The State reserves the right to refuse approval, in its sole discretion, of any proposed subcontract or subcontractor.

The Contractor shall not contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with an individual convicted of crimes described in section 1128(b)(8)(B) of the Social Security Act. The Contractor shall not contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The Contractor shall not contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act. Contractor shall be prohibited from employing or contracting, directly or indirectly, for the furnishing of health care, utilization review, or administrative services with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

The Contractor shall not employ or contract, directly or indirectly, for the furnishing of health care, utilization review, or administrative services with any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act. The Contractor shall not employ or contract, directly or indirectly, for the furnishing of health care, utilization review, or administrative services with any individual or entity that would (or is affiliated with a person/entity that would) provide those services through an individual or entity debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The Contractor shall not employ or contract, directly or indirectly, for the furnishing of health care, utilization review, or administrative services with any individual or entity that would provide those services through an individual or entity excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act.

The contract prohibits the Contractor from knowingly having a subcontractor of the Contractor who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

Contracts between the Contractor and subcontractors shall require the subcontractor to comply with all applicable federal laws, regulations, including applicable subregulatory guidance and contract provisions.

The following shall apply to any of the Contractor's activities or obligations under the contract with the state that are delegated to a subcontractor. First, such activities and obligations, and related reporting responsibilities, are specified in the subcontract between the Contractor and the subcontractor. The subcontract between the

Contractor and the subcontractor must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the state or the Contractor determines that the subcontractor has not performed satisfactorily.

6. Right to Refuse Staff. The State reserves the right, at any time during this Contract, to refuse or reject, in its sole discretion and notwithstanding any prior approval, any of Contractor's Staff based on performance deficiencies and/or lack of knowledge, skills or demonstrated expertise necessary to perform contracted activities. The State will document, in the written notice of rejection that it sends to Contractor, the reason(s) for the rejection of Contractor's Staff.
7. The Contractor shall have appropriate staff member(s) attend on-site meetings held at TennCare offices or at other sites as requested and designated by TennCare.

A.7.b. Staff Requirements Specific to TennCare PBM Programs

1. Key Staff. Contractor's Key Staff are crucial to the operation of each TennCare PBM Program and the satisfactory and timely delivery of each program's services and deliverables. The Contractor shall request approval from the State for all Key Staff candidates prior to assigning them to work on this Contract. The State may, in its sole discretion, require the Contractor's proposed Key Staff candidates to interview with the State. Job descriptions and requirements for each Key Staff position are set forth below in Section A.7.b.4.
2. Key Staff Availability. Unless otherwise indicated, when the term "Full Time" is used in this Contract, it is deemed to mean the indicated Key Staff member shall adhere one hundred percent (100%) to his/her assigned work location and work schedule, with the exception of Contractor corporate meetings, approved leave, or approved use of alternative work sites (AWS). The State may approve use of AWS for Key Staff, but such approval must be given in advance by the State, using the Control Memorandum process set forth in Section A.5, prior to the applicable Key Staff member beginning use of AWS. If TennCare grants approval for AWS to a Key Staff member, the State reserves the right to rescind such approval if, in the sole discretion of the State, it is deemed to be in the best interest of the TennCare PBM Programs for the Key Staff member to work On Site, or the Key Staff member is determined to be violating any of the requirements of this Contract, such as but not limited to, failing to adhere to his/her work schedule or failing to be available to TennCare staff in person, by telephone or by email during those hours.

The Contractor shall ensure that its Key Staff are dedicated one hundred percent (100%) to this Contract. If it is determined that any Key Staff member is working on project(s) other than, or in addition to, this Contract during the hours he/she is required to be devoted to work on the TennCare PBM Programs, such conduct shall, in the sole discretion of the State, be grounds for dismissal of that Key Staff member from this Contract.

TennCare shall supply work space at its offices located in Nashville, Tennessee (hereinafter referred to as "TennCare's Offices" or "On Site") for those Key Staff holding the titles of Account Director, Contract Manager, Clinical PDL Pharmacists, Clinical Administrative Pharmacists, Data Research Analyst, Administrative Technicians and System Liaison, Fraud, Waste and Abuse Investigator, and any associated supervisory and/or support staff. These Key Staff shall be required to work Full Time at TennCare's Offices. The Contractor shall, at a minimum, have at least fifty percent (50%) of its Key Staff On Site at all times during Working Hours, as required to fulfill the Scope of Services specified in this Contract.

The Key Staff members holding the titles of Provider Liaison Pharmacists shall work Full Time in off-site locations as specified in their job descriptions. The Middle Tennessee Provider Liaison Pharmacist shall meet at least twice monthly on site with

the CoverRx Director. The Provider Liaison Pharmacists shall be required to attend training at TennCare's Offices and all Provider Liaison Pharmacists may be requested to attend meetings in person On Site, if deemed necessary by TennCare.

The Contractor is required to have the Account Director (either interim or permanent) hired, trained and On Site beginning on the Contract Effective Date. All permanent Key Staff positions shall be hired and trained no less than sixty (60) days prior to TennCare, CoverKids, and CoverRx Go-Live. Contractor Staff shall report, at the request of the State, to their designated work locations no less than sixty (60) days prior to TennCare, CoverKids and CoverRx Go-Live. Key Staff shall attend all On Site meetings, training sessions, and TennCare orientations prior to TennCare, CoverKids and CoverRx Go Live, as a requirement of the Contractor receiving approval for Go Live for these programs.

3. Key Staff Vacancies. The Contractor shall designate for the State's approval, the specific Key Staff who will fill in for the Account Director and Contract Manager when they are not available On Site. If any Key Staff position becomes vacant, the Contractor shall employ an acceptable replacement within sixty (60) days of the vacancy unless TennCare grants an exception to this requirement. If the Contractor promotes any Staff member who is filling a Key Staff position, the promoted Staff member shall remain one hundred percent (100%) dedicated to the TennCare PBM Programs during the transition and training of the replacement for that Key Staff position, and may be released to his/her newly promoted position only upon approval by TennCare's Chief Pharmacy Officer. The promoted Staff member shall remain available for questions and consultation, as needed, throughout the remainder of the Contract, if he/she remains employed by Contractor.
4. Key Staff Job Descriptions and TennCare PBM Program Requirements. The job titles and current job descriptions and functions for the required Key Staff positions appear below, along with the amount of time each Key Staff member is anticipated to devote to each of the TennCare PBM Programs. These job descriptions and/or allocations of time devoted to each TennCare PBM Program may be modified at any time during the Contract through a Control Memorandum and Control Directive issued by the State. The required Key Staff positions are:
 - (a) TennCare PBM Programs Account Director (Account Director). One (1) Account Director who shall have day-to-day authority to manage all Contract requirements and Contractor's services for all of the TennCare PBM Programs. The Account Director shall be readily available to TennCare staff during Working Hours and shall be available to attend meetings as requested by TennCare. The Account Director shall be one hundred percent (100%) dedicated to the TennCare PBM Programs, with approximately eighty percent (80%) of his/her time devoted to the TennCare PBM Program and the remaining twenty percent (20%) split between the CoverRx and CoverKids PBM Programs. TennCare reserves the right to stipulate, on a day to day basis, which TennCare PBM Program(s) and duties the Account Director shall perform, based on the needs of the State.
 - (b) TennCare PBM Programs Contract Manager (Contract Manager). One (1) Contract Manager whose duties shall include, but are not limited to, being the primary business owner and contact for all TennCare PBM Program "On Request Reports" via TennCare's Team Track system, along with all requests from other TennCare departments related to State Comptroller audits, CMS audits, internal audits, or Program Integrity audits. The Contract Manager shall also be responsible for delivery to the State of all TennCare PBM Program deliverables required by this Contract. The Contract Manager shall also perform similar duties for the CoverRx and CoverKids PBM Programs. The Contract Manager shall be readily available to TennCare staff during Working Hours and shall be one hundred percent (100%) dedicated to

- the TennCare PBM Programs, with approximately eighty percent (80%) of his/her time devoted to the TennCare PBM Program and the remaining twenty percent (20%) split between the CoverRx and CoverKids PBM Programs, on an as needed basis.
- (c) TennCare PBM Programs Clinical Preferred Drug List (PDL) Pharmacists (Clinical PDL Pharmacists). Two (2) Clinical PDL Pharmacists who shall be licensed by the State of Tennessee Board of Pharmacy and whose duties shall include, but are not limited to, all aspects of the TennCare PDL and processes described in Section A.43. The Clinical PDL Pharmacists shall be readily available to TennCare staff during Working Hours and shall be one hundred percent (100%) dedicated to the TennCare PBM Programs.
 - (d) TennCare PBM Programs Clinical Administrative Pharmacists (Clinical Administrative Pharmacists). Three (3) Clinical Administrative Pharmacists who shall be licensed by the State of Tennessee Board of Pharmacy and whose duties shall include, but are not limited to, support for the TennCare PA process, TennCare First Level Appeals process, TennCare Pharmacy Lock-In process, and assistance with the TennCare Pharmacy Audit process. The Clinical Administrative Pharmacists shall be readily available to TennCare staff during Working Hours and shall be one hundred percent (100%) dedicated to the TennCare PBM Programs.
 - (e) TennCare PBM Program Provider Liaison Pharmacists (Provider Liaison Pharmacists). Three (3) Provider Liaison Pharmacists who are licensed by the State of Tennessee Board of Pharmacy and shall be field-based as follows: one in East Tennessee, one in Middle Tennessee, and one based in West Tennessee. The Provider Liaison Pharmacists shall spend approximately eighty percent (80%) of their time on the TennCare PBM Program, which shall include, but is not limited to, follow-up after audit and audit assistance, academic detailing of prescribers and pharmacy providers, TennCare PDL compliance initiatives, DUR and Provider Practice Activity follow up, and education and assistance for Providers in working with TennCare Program utilization management programs (i.e. PA requests, attestations, emergency supply), and performing similar duties for the CoverRx and CoverKids Programs. The Provider Liaison Pharmacists shall be one hundred percent (100%) dedicated to the TennCare PBM Programs. The Middle Tennessee Provider Liaison Pharmacist shall also devote up to an additional fifteen percent (15%) of his/her time to performing the duties described in Sections A.7.b.4(c), (d), and (g) and other duties as requested for the CoverRx and CoverKids PBM Programs.
 - (f) TennCare PBM Program Data Research Analyst (Data Research Analyst). One (1) Data Research Analyst who shall be responsible to generate daily, weekly, monthly, quarterly and yearly reports required by the Contract and all ad hoc report requests made by TennCare. The Data Research Analyst shall be an expert in the data that is warehoused by the Contractor on behalf of TennCare and shall be available to assist TennCare staff with Contractor's decision support systems, as requested. The Data Research Analyst shall be readily available to TennCare staff during Working Hours and shall be one hundred percent (100%) dedicated to the TennCare, CoverRx and CoverKids PBM Programs, with approximately eighty percent (80%) of his/her time dedicated to the TennCare PBM Program and the remaining twenty percent (20%) dedicated to the CoverRx and CoverKids PBM Programs, on an as needed basis.
 - (g) TennCare PBM Programs Administrative Technicians (Administrative Technicians). Two (2) Administrative Technicians who shall be responsible

for, but not limited to, assisting TennCare staff with TennCare appeals and Lock-In requirements, communications with Pharmacy Advisory Committee (PAC) and Drug Utilization Review (DUR) Board members, the facilitation of Board meetings, coordination of TennCare enrollee and Provider mailings and other communications, and any other tasks assigned by the Account Director. The Administrative Technicians shall be readily available to TennCare staff during Working Hours and shall be one hundred percent (100%) dedicated to the TennCare PBM Programs.

- (h) TennCare PBM Programs System Liaison (System Liaison). One (1) System Liaison who shall be responsible for, but not limited to, the planning and timely coding of edits, as requested by TennCare, to the Contractor's system that provide services to the TennCare, CoverRx and CoverKids PBM Programs, quality control of such edits to ensure proper functioning within the system, and ensuring that newly entered system changes and edits do not affect existing edits within the Contractor's system causing unanticipated adverse system events affecting any TennCare PBM Program claims, enrollees or Providers. The System Liaison shall be responsible for all testing of new programs or modules to be used by Contractor to manage TennCare's PBM Programs and shall also be responsible for the maintenance and management of the Contractor's website that serves all TennCare PBM Programs, including updating PDL changes, changes to clinical criteria, and other website changes, such as but not limited to, drug reimbursement changes updates. The System Liaison shall be readily available to TennCare staff during Working Hours and shall be one hundred percent (100%) dedicated to the TennCare PBM Programs.
- (i) TennCare Fraud and Abuse Investigators. One (1) Fraud and Abuse Investigator dedicated to TennCare who shall be responsible for all fraud and abuse detection activities for the TennCare PBM Programs, including the Fraud and Abuse Compliance Plan, and who will be the Key Staff handling day-to-day Provider investigation-related inquiries from TennCare. This Fraud and Abuse Investigator shall be assisted, on an as needed basis, with up to two (2) other designated Fraud and Abuse Investigators and one (1) staff person all of whom may be located in the Contractor's corporate offices, but who have full knowledge of Provider investigations related to the TennCare PBM Programs and shall work with the TennCare Office of Program Integrity (OPI).

A.8. TennCare PBM Programs Member Materials.

A.8.a. Prior Approval Process for Contractor Communication with TennCare Members. The Contractor shall submit to TennCare for review and prior written approval all materials that will be distributed to members (referred to as member materials). Contractor shall not distribute any member material without receiving prior written approval from TennCare. Should the Contractor decide to contract with either a subcontractor or its providers to create and/or distribute member materials, the materials shall not be distributed to members unless the materials have been submitted to TennCare by the Contractor for review and prior written approval and TennCare has provided prior written approval. Member Materials include, but are not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, system generated letters and any other additional, but not required, materials and information provided to members designed to promote health and/or educate members.

1. All member materials shall be submitted to TennCare on paper and electronic file media, in the format prescribed by TennCare. The materials shall be accompanied by a plan that describes the Contractor's intent and procedure for the use of the materials. Materials developed by a recognized entity having no association with the Contractor that are related to management of specific types of diseases (e.g., heart,

diabetes, asthma, etc.) or general health improvement shall be submitted for approval; however, unless otherwise requested by TennCare, an electronic file for these materials is not required. The electronic files shall be submitted in a format acceptable to TennCare. Electronic files submitted in any other format than those approved by TennCare will not be processed.

2. TennCare shall review the submitted member materials and either approve or deny them within fifteen (15) calendar days from the date of submission. In the event TennCare does not approve the materials TennCare may provide written comments, and the Contractor shall resubmit the materials.
3. Once member materials have been approved in writing by TennCare, the Contractor shall submit to TennCare an electronic version (PDF) of the final printed product, unless otherwise specified by TennCare, within thirty (30) calendar days from the print date. Should TennCare request original prints be submitted in hard copy, photo copies may not be submitted as a final product. Upon request, the Contractor shall provide additional original prints of the final product to TennCare.
4. Prior to modifying any approved member material, the Contractor shall submit for written approval by TennCare a detailed description of the proposed modification. Proposed modifications shall be submitted in accordance with the requirements herein.
5. TennCare reserves the right to notify the Contractor to discontinue or modify member materials after approval.

A.8.b. The Contractor shall comply with the following requirements as it relates to written member materials.

1. All member materials shall be worded in Plain Language in a manner and format that may be easily understood and is readily accessible by enrollees and potential enrollees, unless the State approves a different standard. Articles and/or informational material included in written materials such as newsletters, brochures, etc. shall be limited to approximately 200 words for purposes of readability unless otherwise approved in writing by TennCare. Written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices shall be available in the prevalent non-English languages in Tennessee;
2. All written materials shall be clearly legible and unless otherwise directed by TennCare must be written with a minimum font size of 12pt. with the exception of member I.D. cards and certain taglines that require a minimum font size of 18 pt. Any request from the Contractor for an exception to the written materials font size requirements shall be approved in writing by TennCare prior to use;
3. All written materials shall be printed with the notice of non-discrimination and taglines as required by TennCare and set forth in TennCare's tagline template. In addition to any other requirements specified in this section, the Contractor may also provide required member materials/information electronically or on its website pursuant to the specifications set forth in section A.6 Nondiscrimination Compliance Requirement's and TennCare's tagline template, and the following requirements: (1) the material/information must be placed on the Contractor's website in a location that is prominent and readily accessible for applicants and members to link to from Contractor's home page; (2) the material/information must be provided in a format that can be electronically saved and printed; and (3) if a member or applicant requests that the Contractor mail them a copy of the material/information, the Contractor must mail free of charge the material/information to them within five (5) days of that request. To the extent that the Contractor and its providers and/or subcontractors are using electronic and information technology to fulfill its obligations

under this Contract, the entities shall comply with section A.6 Nondiscrimination Compliance Requirement's;

4. All written member materials shall ensure effective communication and be made available in alternative formats at the request of the enrollee, potential enrollee, or their representatives in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency. These alternative formats shall be free of charge to the individual. Alternative formats may include, but are not limited to: Auxiliary aids or services, such as, Braille, large print, and audio; American Sign Language interpretation, written translations, and language assistance services and shall be based on the needs of the individual. The Contractor shall have processes in place to ensure that the individual is immediately accessed by its Nondiscrimination Compliance Coordinator for the need for an alternative format material. Should the assessment determine that the provision of the alternative format is reasonable the alternative format will be made available to the individual in a timely manner, (i.e. as-soon-as practicable). The Contractor and its providers and direct service subcontractors shall be required to comply with the applicable civil rights laws in the provision of free language and communication assistance services to enrollees, potential enrollees, or their representatives;
5. All written material shall inform enrollees and potential enrollees as how to obtain materials in alternative formats and how to access oral interpretation services and that both alternative formats and interpretation services are available at no expense to the individual. This information shall be considered a Vital Document and shall be available at a minimum in the English and Spanish languages;
6. All written material shall include notice of the right to file a discrimination complaint as set forth in Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, 42 U.S.C. § 18116 (codified at 45 C.F.R. pt. 92), and the Age Discrimination Act of 1975. This notice shall be considered a Vital Document and shall be available at a minimum in the English and Spanish languages;
7. The following shall not be used on any written materials, including but not limited to member materials, without the written approval of TennCare:
 - (a) The Seal of the State of Tennessee;
 - (b) The TennCare, CoverKids, or CoverRx name unless the initials "SM" denoting a service mark, is superscripted to the right of the name (TennCareSM);
 - (c) The word "free" unless the service is at no cost to all members. If members have cost sharing or patient liability responsibilities, the service is not free. Any conditions of payments shall be clearly and conspicuously disclosed in close proximity to the "free" good or service offer; and
 - (d) The use of phrases to encourage enrollment such as "keep your pharmacy or benefits" implying that enrollees can keep all of their providers or must enroll in order to keep or not lose benefits. Enrollees in TennCare shall not be led to think that they can continue to go to their current provider, unless that particular provider is a contract provider with the Contractor.
 - (e) The Contractor's member materials shall not mislead, confuse, or defraud enrollees or the State;

- (f) The Contractor's member materials shall not contain any assertion or statement (whether written or oral) that the Contractor is endorsed by CMS, the Federal or State government, or a similar entity.
 - 8. The Contractor shall provide written notice to members of any changes in policies or procedures described in written materials previously sent to members. The Contractor shall provide written notice at least thirty (30) days before the effective date of the change;
 - 9. The Contractor shall notify enrollees when it adopts a policy to discontinue coverage of a counseling or referral service based on moral/ethical or religious objections at least thirty (30) days prior to the effective date of the policy for any particular service;
 - 10. All educational materials (brochures, scripts etc.) shall be reviewed and updated concurrently with the update of the Clinical Practice Guidelines to assure the materials reflect current evidence-based information.
 - 11. The Contractor shall use the state-developed definition for the following terms: appeal; co-payment; durable medical equipment; emergency medical condition; emergency medical transportation; emergency room care; emergency services; excluded services; grievance; habilitation services and devices; health insurance; home health care; hospice services; hospitalization; hospital outpatient care; medically necessary; network; nonparticipating provider; participating provider; physician services; plan; preauthorization; premium; prescription drug coverage; prescription drugs; primary care physician; PCP; provider; rehabilitation services and devices; skilled nursing care; specialist; and urgent care;
 - 12. The Contractor shall use State developed enrollee notices;
- A.8.c. Distribution of Member Materials. The Contractor shall distribute member materials as required by this Contract. Required member materials include, but are not limited to provider directories, Formulary, identification cards, enrollee educational material; and notices.
- A.8.d. Member Material Dissemination. The member material information shall be considered to be provided to enrollees if the Contractor:
- 1. Mails a printed copy of the information to the enrollee/member's mailing address;
 - 2. Provides the information by email after obtaining the enrollee's agreement to receive the information by email;
 - 3. Posts the information on its website and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or
 - 4. Provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.
- A.9. Tennessee Medicaid Provider Number Requirement. The Contractor shall ensure that each of its Providers who perform services for the TennCare PBM Programs pursuant to this Contract shall comply with all requirements set forth in this Contract and the Contractor's TennCare approved provider service agreement (Provider Service Agreement) and addendum (Addendum), if applicable, described in Section A.10 below. In addition, the Contractor shall require each Provider to:
- A.9.a. Agree to provide services to enrollees of each of the following TennCare PBM Programs, unless such requirement is waived in writing by the State:

1. TennCare,
2. CoverRx, and
3. CoverKids

A.9.b. Obtain a Tennessee Medicaid provider number via TennCare's Provider Services registration process and continue to meet all requirements for obtaining a Tennessee Medicaid provider number for the entire period of time it is a Provider. Contractor shall not pay any claim related to any of the TennCare PBM Programs unless the provider has a Tennessee Medicaid provider number.

A.10. TennCare, CoverRx and CoverKids PBM Program Provider Networks and Provider Service Agreements/ Addenda. The Contractor shall maintain and monitor a network of appropriate Providers that is sufficient to provide adequate access to all services covered under the Contract for all enrollees, including those with limited English proficiency or physical or mental disabilities. The Contractor shall use only preapproved standard Provider Agreements pursuant to templates supplied by TennCare that include requirements for providing PBM services to TennCare, CoverRx and CoverKids enrollees in exchange for payment from the State for services rendered. The Contractor shall also enter into standard Addenda to Provider Service Agreements when appropriate and necessary to provide all PBM services required herein. Such Addenda shall be approved templates supplied by TennCare that include requirements for certain TennCare PBM Program services such as, but not limited to, MTM or other specialty PBM services. The Contractor shall make every effort to enter into Provider Service Agreements/Addenda with Providers whose practices exhibit a substantive balance between non-commercial customers, such as TennCare and CoverRx enrollees, and commercial customers, such as CoverKids enrollees. Provider Service Agreements/Addenda shall be between Providers and the Contractor, not between Providers and the State. The Contractor shall have sole responsibility for the establishment and management of its Provider networks, including termination of any Provider Service Agreement/Addendum due to a Provider's failure to maintain a Tennessee Medicaid provider number or comply with any requirement of the Contract or the Provider Service Agreement/Addendum.

The Contractor shall comply with the following requirements pertaining to Provider Service Agreements/Addenda:

A.10.a. The Contractor shall submit one (1) complete copy of each template Provider Service Agreement/Addendum, and any revisions thereof, to TennCare once they have been approved by the Tennessee Department of Commerce and Insurance (TDCI) and prior to entering into such agreements with Providers. The Contractor shall also provide TennCare with copies of the face and signature pages of all fully executed Provider Service Agreements/Addenda no later than thirty (30) days prior to Go Live of the TennCare and CoverRx PBM Programs. Thereafter, Contractor shall provide TennCare with any new Provider Service Agreements/Addenda it enters into, as well as any documentation evidencing termination of any Provider Service Agreements/Addenda, within five (5) business days of full execution of such documents. All documentation required to be provided pursuant to this Section A.10.a shall be transmitted using the electronic format specified in writing by the State.

A.10.b. The Contractor shall only execute Provider Service Agreements/Addenda with Provider pharmacies that have completed TennCare's electronic provider registration process, have been issued a current valid TennCare Provider number, been placed in an eligible pool of providers from which the Contractor can select its Providers for the TennCare PBM Programs. All Providers shall maintain all required federal, state and local licenses, certifications, and permits, without restriction, necessary to provide pharmaceutical services to TennCare PBM Program enrollees, and that fully comply with all applicable State and federal laws and regulations. All network decisions are completely the responsibility of the Contractor. The Contractor shall be responsible for oversight of its Providers and enforcement of the Provider Service Agreements/Addenda. Any Provider that has been disciplined or sanctioned by the State Pharmacy Board or federal authority or has breached its Provider

Service Agreement/Addendum shall be investigated and audited by the Contractor. Contractor shall report the results of its investigation of such Provider and its audit results and findings to the State within sixty (60) days of any disciplinary action, sanction or Contract breaches, along with any action taken by the Contractor.

- A.10.c. The Contractor shall ensure Provider compliance with State and federal prescribing laws requiring written prescriptions only be filled if they are presented on an approved tamper proof form. The Provider Service Agreement shall state that the failure of a Provider to follow these laws shall be grounds for dismissal from the Contractor's network as a Provider for the purposes of providing service to the TennCare PBM Programs.
- A.11. The Contractor shall provide for resolution of disputes with its Providers either by arbitration or another process mutually agreed to by the parties. The Provider Service Agreement shall specify that the TennCare Provider Independent Review of Disputed Claims process is available to Providers to resolve claims denied in whole or in part by the Contractor as provided at T.C.A. § 56-32-126(b).
- A.12. Deficiency in Contractor's TennCare PBM Program Provider Network. Upon notification from the State of a deficiency in Contractor's TennCare PBM Program network, which shall be based on the Terms and Conditions for Access contained in the TennCare Program State Plan and Waivers and the CoverKids State Plan, the Contractor shall immediately provide written notice to TennCare and CoverKids enrollees living in the affected area of a Provider shortage in the Contractor's PBM network. The notice content shall be reviewed and approved by the State prior to distribution.
- A.13. Provider Sole Service Agreements. The Contractor shall assure the provision of all covered PBM services specified in this Contract. When necessary to fulfill the terms of this Contract, the Contractor shall enter into short term agreements with non-network pharmacy providers who shall provide pharmacy services to enrollees for a specified period in exchange for payment from the Contractor for services rendered. The Contractor shall make every effort to enter into approved Provider Service Agreements/Addenda with such entities under the same rules and regulations as outlined in the Provider Service Agreements/Addenda for in-network Providers.
- A.14. Non-Network Providers. The Contractor shall not deny any licensed pharmacy or licensed pharmacist the right to participate as a participating Provider in any policy, contract or plan on the same terms and conditions as are offered to any other providers of pharmacy services under the policy, contract or plan. The Contractor shall provide an emergency override process, at no additional cost to the State, whereby a non-network pharmacy may be approved to process a claim for a TennCare PBM Program recipient in an emergency, and when the use of a network pharmacy Provider is not an option. All claims filled from non-network pharmacies are to be reported to the State on a weekly basis. This non-network emergency override process will be subject to the State's approval. In addition, the Contractor shall make information regarding its Provider network readily available on its website and through its Pharmacy Help Desk.
- The Contractor shall coordinate payment with non-network providers and ensure the cost to the enrollee is no greater than it would be if the services were furnished within the network.
- A.15. Contractor Written Policies and Procedures - Selection/Retention of Providers. The Contractor shall have in place TennCare approved, written policies and procedures for the selection and/or retention of Providers, based on the State's policies and procedures. Contractor shall not discriminate against pharmacy providers that service high risk populations or specialize in conditions that require costly treatment.

The Contractor shall not discriminate against any provider (limiting their participation, reimbursement or indemnification) who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

In all contracts with network providers, the Contractor's provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

The Contractor shall not be required to contract with more providers than necessary to meet the needs of its enrollees.

The Contractor shall not be precluded from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.

The Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:

- A.15.a. The member's health status, medical, behavioral health, or long-term care, or treatment options, including any alternative treatment that may be self administered;
- A.15.b. Any information the member needs in order to decide among all relevant treatment options;
- A.15.c. The risks, benefits, and consequences of treatment or non-treatment; or
- A.15.d. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

The Contractor shall not take punitive action against a provider who either requests an expedited resolution or supports an enrollee's appeal.

The Contractor shall require that subcontractors and referral providers not bill enrollees for covered services, any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by providers).

- A.16. Written Notice Requirement - Pharmacy Providers Not Included in Network. If the Contractor declines to include an individual pharmacy provider or group of pharmacy providers in its Provider network serving TennCare PBM Program enrollees, the Contractor shall give the affected pharmacy providers written notice of its decision.
- A.17. Provider Network Data. In accordance with the following paragraph, the Contractor shall deliver to the State in a State-approved format, a list of its current Provider network including, but not limited to, demographic and credentialing information (Provider Network Data).

The Contractor shall submit Provider Network Data:

- 1) At the time when the Contractor enters into this Contract with the State;
- 2) Annually thereafter on a date determined by the State;
- 3) At any time there occurs, in the sole discretion of the State, a significant change in the Contractor's operations that would affect the adequacy of capacity and services, including without limitation changes in Contractor's services, benefits, geographic service area, composition of or payments to its provider network, or at the enrollment of a new population; and
- 4) At such other times when the State so requests in writing.

- A.18. State Audit of Contractor.

The contractor shall submit audited financial reports specific to the contract on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

The State reserves the right to audit or investigate all PBM services performed by the Contractor and its Providers and subcontractors, as well as the Contractor's compliance with the provisions of this Contract. Audits or investigations may, at the option of the State, be performed by the State, or another state or federal entity, such as but not limited to, the Tennessee Comptroller of the Treasury, or by an audit contractor procured by TennCare (TennCare Auditor). Contractor shall cooperate in the performance of audits or investigations and shall provide all documents, TennCare Records and other information requested by the entity performing the audit or investigation, and provide prompt access to any and all systems, datasets, reports, deliverables, testing results, books, records, contracts, computer, or other electronic systems that pertain to any aspect of services and activities performed or determination of amounts payable under the Contractor's contract with the State, and other materials the State deems necessary. This applies for all audits conducted within the contract period and covers the resolution of any outstanding items required of the Contractor to complete the audit, even after the contract period ends. The Contractor shall provide such documentation and system access in a timely manner in compliance with written notice provided to the Contractor. The Contractor shall also make available to the entity performing the audit or investigation all applicable Contractor Staff necessary to provide complete responses to the auditing or investigating entity's inquiries. All of the Contractor's costs or expenses of any kind associated with such audits or investigations, including the production of TennCare Records and other information, shall be the sole responsibility of the Contractor.

- A.19. Records Retention. The Contractor and its Providers and subcontractors shall maintain TennCare Records necessary to demonstrate that covered services were provided in compliance with State and federal requirements. An adequate TennCare Records retention system shall be created and maintained by the Contractor. All TennCare Records shall be maintained for ten (10) years from the close of the relevant Contract or agreement (behavioral health records shall be maintained at the Provider level for ten (10) years after the termination of the Contract pursuant to TCA §33-3-101) or retained until all evaluations, audits, reviews or investigations or prosecutions are completed.
- A.20. Records Access. Pursuant to 42 CFR §438.3, the State, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of an MCO, PIHP, PAHP, PCCM or PCCM entity, or its subcontractors, and may, at any time, inspect the premises, physical facilities, equipment where TennCare-related activities or work is conducted, books, records, contracts, computer, or other electronic systems relating to its TennCare enrollees. The right to audit under this Section A.20 exists for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Said records shall be made available at no cost to the requesting agency. At the discretion of the requesting agency, "access" may include an examination of the records located in any electronic health records system, as well as related information such as metadata and audit trails.
- A.21. Records Discovery. In addition to the TennCare Records audits and investigations referenced above, the Contractor shall make available all TennCare Records of whatever type (correspondence, memoranda, databases, worksheets, training material, etc.), in their original form, be it electronic or paper, including emails with metadata preserved. These TennCare Records shall be produced to the State at no cost to the State, as required to satisfy evidence discovery demands of any of litigation, including State or federal class action, affecting the State. The State shall endeavor to keep the evidence discovery requests as limited as reasonably possible. The Contractor shall retain the right to object in court to any evidence discovery requests it may feel is too broad or otherwise unduly burdensome.
- A.22. Fraud and Abuse Compliance Plan Requirements for the TennCare PBM Programs. The Contractor shall have State approved policies and procedures in place for ensuring protections against actual or potential fraud and abuse. The Contractor may use a single Fraud and Abuse Compliance Plan for all TennCare PBM Programs, provided the plan meets all needs of each TennCare PBM Program. The detailed Fraud and Abuse Compliance Plan shall define how the Contractor shall adequately identify and report suspected fraud and abuse by recipients, providers, subcontractors, and the Contractor, and shall include a

requirement that, in addition to reporting suspected fraud and abuse to the State and other entities as required herein, the Contractor shall also, within the same required period of time, report all suspected fraud and abuse to the TennCare Office of Program Integrity (OPI) and the TennCare Pharmacy department. The Fraud and Abuse Compliance Plan shall be updated, if applicable, and submitted on a yearly basis to the State on the Contract Effective Date anniversary. The Contractor shall meet with the State to discuss the monitoring tools and controls necessary to protect against theft, embezzlement, fraudulent practices or other types of fraud and program abuse, and describe the type and frequency of training that shall be provided by the Contractor to its Staff to assist them in detecting fraud. All fraudulent activities or other program abuses shall be subject to the laws and regulations of the State of Tennessee and/or federal laws and regulations. The Contractor's Fraud and Abuse Compliance Plan shall address, at a minimum, the following requirements:

- A.22.a. **Written Policies and Procedures.** The Contractor shall develop written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state standards for the prevention, detection and reporting of incidents of potential fraud and abuse by members, providers, subcontractors and the Contractor.
- A.22.b. **Compliance Officer.** The Contractor shall designate a Compliance Officer and a Compliance Committee, accountable to senior management, to coordinate with TennCare and other state agencies on any fraud or abuse case. The Contractor may identify different contacts for member fraud and abuse, provider fraud and abuse, subcontractor fraud and abuse, and Contractor fraud and abuse.
- A.22.c. **Training and Education.** The Contractor shall establish effective program integrity training and education for the Compliance Officer and all Contractor staff, employees and subcontractors.
- A.22.d. **Effective Lines of Communication between Contractor Staff.** The Contractor shall establish effective lines of communication between the Compliance Officer and other Contractor Staff.
- A.22.e. **Well-Publicized Disciplinary Guidelines.** The Contractor shall enforce program integrity standards through well-publicized disciplinary guidelines.
- A.22.f. **Internal Monitoring and Audit.** The Contractor shall establish and implement procedures for internal monitoring and auditing. These activities and their reporting mechanism shall be defined in the Fraud and Abuse Compliance Plan.
- A.22.g. **Process for Reporting Potential or Actual Fraud and Abuse.** The Contractor shall provide information and a procedure for members, providers, Contractor staff, employees and subcontractors to report incidents of potential or actual fraud and abuse to the Contractor and to TennCare, in a manner and format required by TennCare.
- A.22.h. **Development of Corrective Action Initiatives.** The Contractor's Fraud and Abuse Compliance Plan shall include provisions for corrective action initiatives.
- A.22.i. **Model Compliance Plan for HMOs.** The Contractor's Fraud and Abuse Compliance Plan shall comply with the applicable requirements of the Model Compliance Plan for Medicaid MCOs, including but not limited to PAHPs, issued by the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG).
- A.22.j. **Cooperation with State and Federal Investigations.** The Contractor's Fraud and Abuse Compliance Plan shall include provisions for cooperating with all fraud and abuse investigation efforts by TennCare and other state and federal offices.
- A.23. **TennCare PBM Program Integrity Reporting Requirements.**

A.23.a. In a form and manner specified by the State, the Contractor shall submit a Quarterly Fraud and Abuse Activity Reports for the TennCare Program and CoverKids Program, which shall include, at a minimum, the following Program Integrity related activities:

1. Tips reported,
2. Audits performed,
3. Referrals made,
4. Overpayments collected,
5. Education provided to providers
6. Involuntary terminations,
7. Providers with adverse PI actions, and
8. Enrollees referred to the OIG.

The Contractor shall meet with TennCare's Office of Program Integrity to review all TennCare and CoverKids Program fraud activities quarterly. The Contractor shall have appropriate staff member(s) attend on-site meetings held at TennCare offices or at other sites as requested and designated by TennCare.

The State will monitor the delivery and content of these reports and notify the Contractor of any violations as well as any possible sanctions related to those violations. The Contractor shall have thirty (30) calendar days, following written notification, to correct all violations prior to assessment of Liquidated Damages by the State. The Contractor shall submit a corrective action plan for each violation to the State, within five (5) business days of receipt of written notification of potential TennCare or CoverKids Program violations and/or written notification of possible sanctions. At the State's option, such notices will be sent to the Contractor via electronic means or certified U.S. Mail.

A.23.b. The Contractor shall provide separate monthly reports to the State that describe TennCare PBM Program Provider dispensing patterns that statistically identify the pharmacy as an outlier that may be representative of potential fraudulent, abusive or wasteful dispensing patterns. Additionally, the Contractor shall provide specific recommendations to the State, via a plan of correction that will eliminate the potentially fraudulent, abusive or wasteful dispensing patterns of these specific TennCare PBM Program Providers. The reports shall be due on the fifteenth (15th) day of the month for the previous month's pharmacy claims in a form and manner specified by the State. The report shall be independent of routine audit activities, and shall include, but not be limited to, referrals made to the Contractor by:

1. Network pharmacies,
2. Prescribers,
3. TennCare's Office of Program Integrity,
4. Tennessee Bureau of Investigation,
5. Tennessee Medicaid Fraud Control Unit, and
6. State of Tennessee's Office of Inspector General.

A.24. TennCare and CoverKids Program Fraud and Abuse; Tennessee Bureau of Investigation (TBI) Medicaid Fraud Control Unit (MFCU) Access to Contractor and Provider TennCare/CoverKids Records; Office of TennCare Inspector General (TennCare OIG) Access to Contractor, TennCare/CoverKids Provider, and TennCare/CoverKids Enrollee Records.

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, MFCU and TennCare OIG shall be health oversight agencies as defined at 45 C.F.R. §§ 164.501 and 164.512(d) and 65 F.R. § 82462. When acting in their respective capacities as health oversight agencies, MFCU and TennCare OIG do not need authorization to obtain TennCare and CoverKids enrollee protected health information (PHI). Because MFCU and TennCare OIG will request the information mentioned above for health oversight activities, "minimum necessary" standards do not apply to disclosures to MFCU or TennCare OIG that are required by law. See 45 C.F.R. §§ 164.502(b)(2)(iv), 164.502(b)(2)(v), and 164.512(d).

- A.24.a. The Contractor shall report all tips of confirmed or suspected TennCare and CoverKids Provider fraud and abuse to OPI and TennCare Pharmacy on the 1st and 15th of each month.
- A.24.b. The Contractor shall report all possible TennCare and CoverKids fraud and abuse to the State and the appropriate agency as indicated below. The provisions of this subsection do not apply to the CoverRx Program.
1. Possible enrollee fraud and abuse shall be reported immediately to OIG;
 2. Possible provider fraud and abuse shall be reported immediately to OPI and MFCU; and
 3. Possible fraud and abuse by the Contractor in the administration of the program shall be reported to OPI and MFCU.
- A.24.c. Unless prior written approval is obtained from the agency to which the incident was reported, or to another agency designated by the agency that received the report, after reporting possible TennCare or CoverKids fraud or abuse, the Contractor shall not take any of the following actions as they specifically relate to TennCare and CoverKids claims:
1. Contact the subject of the investigation about any matters related to the investigation;
 2. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
 3. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
- A.24.d. This Section applies even if the source of the reported activity is an audit or investigation done by another State or federal agency (e.g. Comptroller's office, licensing agency) as these investigations or audits often have Program Integrity implications. The Contractor shall promptly provide the results of its preliminary investigation to the agency to which the incident was reported, or to another agency designated by the agency that received the report.
- A.24.e. The Contractor shall cooperate with all appropriate State and federal agencies, including TBI MFCU and/or OIG, in investigating TennCare PBM Program fraud and abuse. In addition, the Contractor shall fully comply with the TCA §§ 71-5-2601 and 71-5-2603 in performance of its obligations under this Contract.
- A.24.f. Enrollee Records Consent. As a condition of participation in the TennCare PBM Programs, enrollees shall give the State, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCU, DHHS Office of Inspector General (DHHS OIG), and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the Contractor for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the Contractor, the State or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCU, the DHHS OIG and the DOJ, at no cost to the requesting party.
- A.24.g. The State, DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCU, DOJ and their authorized agents, as well as any authorized State or federal agency or entity shall have the right to access through inspection, evaluation, review or request, whether announced or unannounced, or other means any TennCare PBM Program records pertinent to this Contract including, but not limited to medical records, billing records, financial records (including IRS 1099 forms), and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution.
1. Such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the Contractor, during Working

Hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the requesting agency.

2. Upon request, the Contractor shall assist in such reviews, including the provision of complete copies of all records at no cost to the requesting agency.
3. The Contractor acknowledges that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to TennCare, OIG, TBI MFCU, DHHS OIG and DOJ and their authorized agents. Any authorized state or federal agency or entity, including, but not limited to TennCare, OIG, TBI MFCU, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, may use these records and information for medical audit, medical review, utilization review and administrative, civil or criminal investigations and prosecutions.

A.25. Prevention/Detection of TennCare PBM Program Provider Fraud and Abuse. The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected TennCare and CoverKids fraud and abuse activities, as detailed in 42 CFR §438.608. Such internal controls and policies and procedures shall include the following:

A.25.a. A compliance program that includes, at a minimum, all of the following elements:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable federal and State requirements;
2. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the Board of Directors;
3. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Contract;
4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and State standards and requirements under the contract;
5. Effective lines of communication between the Compliance Officer and the organization's employees;
6. Enforcement of standards through well-publicized disciplinary guidelines; and
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.

A.25.b. Provision for implementation and maintaining arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State.

A.25.c. Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to

participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP.

- A.25.d. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.
- A.25.e. In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least \$5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers. The provisions of this subsection do not apply to the CoverRx PBM Program.
- A.25.f. Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit. CoverRx PBM Program reporting does not include a report to the State Medicaid Fraud Control Unit.
- A.25.g. Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with § 455.23 of CFR §438.60842. This subsection does not apply to the CoverRx PBM Program.
- A.26. TennCare and CoverKids Claims Attestation. The following claims attestation requirement only applies to the TennCare PBM Program and the CoverKids PBM Program. Per 42 CFR §§ 455.18 and 455.19, the following statement shall be included in any Agreement that an Managed Care Contractor (MCC) (including a PAHP) has with its subcontractors and/or providers: "I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws."
- A.27. TennCare PBM Programs Recoupment, Recovery and/or Withhold of Overpayments. The following recoupment, recovery and/or withhold of overpayment requirements apply to the TennCare PBM Programs.
 - A.27.a. Reporting Overpayments.
 - 1. The Contractor, its Staff and Providers shall report overpayments and, when it is applicable, return overpayments within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may result in a penalty pursuant to State or federal law.
 - 2. The Contractor shall report to TennCare OPI and TennCare Pharmacy all overpayments, both identified and recovered, on a quarterly basis.
 - A.27.b. Prohibition against Recoupment, Recovery, and/or Withhold of Overpayments.
 - 1. The Contractor is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a Provider when the issues, services, or claims upon which the recoupment or withhold are based meet the following criteria:
 - (a) The improperly paid funds have already been recovered by the State of Tennessee, either by TennCare directly or as part of a resolution of a State or federal investigation and/or lawsuit, including but not limited to False Claims Act cases; or

- (b) When the issues, services, or claims that are the basis of the recoupment or withhold are currently being investigated by the State or are the subject of pending State or federal litigation or investigation.
 - 2. The Contractor shall determine if the prohibition to recoup or withhold improperly paid funds is applicable utilizing methods as directed by OPI.
 - 3. In the event the Contractor recoups or otherwise obtains funds in cases where overpayment recovery is prohibited under this section, or as otherwise directed by OPI, the Contractor will notify the Director of OPI and take action in accordance with written instructions from the Director of OPI.
- A.28. False Claims. The Contractor, its Staff and Providers shall comply with the provisions of 42 U.S.C. § 1396a(a)(68) *et seq.* (Federal False Claims Act) as applicable, with regard to the TennCare and CoverKids Programs regarding policies and education of employees as regards the terms of the False Claims Act and whistleblower protections. The Federal False Claims Act does not apply to the CoverRx Program, but the Contractor, its Staff and Providers shall comply with all provisions of the Tennessee False Claims Act (Tennessee False Claims Act) set forth in Tenn. Code Ann. § 4-18-101, *et seq.*
- A.29. The Contractor shall submit annual reports for both TennCare and CoverKids to TennCare and the State Office of the Inspector General that includes summary results of any fraud and abuse tests performed at the request of the State and detailed in the Contractor's TennCare and CoverKids Fraud and Abuse Compliance Plans. The reports shall cover results for each fiscal year of the Contract term ending June 30 and shall be submitted by September 30 of each year. The information in these reports shall be provided in accordance with and in a format as described in the Contractor's approved TennCare and CoverKids Fraud and Abuse Compliance Plans.
- A.30. TennCare PBM Program Ownership and Control Disclosure Information.
- A.30.a. The Contractor shall submit:
- 1. The name and address of any person (individual or corporation) with an ownership or control interest in the managed care entity and its subcontractors. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
 - 2. The date of birth and Social Security Number (SSN) of any individual with an ownership or control interest in the Contractor and its subcontractors.
 - 3. Other tax identification number of any corporation with an ownership or control interest in the Contractor and any subcontractor in which the Contractor has a five (5) percent or more interest.
 - 4. Information on whether an individual or corporation with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling.
 - 5. Information on whether a person or corporation with an ownership or control interest in any subcontractor in which the Contractor has a five (5) percent or more interest is related to another person with ownership or control interest in as a spouse, parent, child, or sibling.
 - 6. The name of any other disclosing entity in which an owner of the Contractor has an ownership or control interest.
 - 7. The name, address, date of birth, and SSN of any managing employee of the Contractor.

- A.30.b. The Contractor and its subcontractors shall disclose to TennCare, the Comptroller, Office of Inspector General of the United States, or CMS full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid or the federal Title XX programs in the time and manner set forth in accordance with federal and state requirements, including 42 CFR §455.104 and Public Chapter 379 of the Acts of 1999.
- A.30.c. TennCare will collect Disclosure of Ownership information for both Individual Provider Persons and Provider Groups/Entities when a provider registers/re-verifies with TennCare including complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the federal Title XX programs in the time and manner set forth in accordance with federal and state requirements, including but not limited to 42 CFR §455. These disclosures shall be made in the form and manner determined by TennCare.
- A.30.d. Program Ownership and Control Disclosure information will be sent to the Contractor, once a provider registers/re-verifies with the state, on a Disclosure Data sharing file submitted weekly. The Contractor shall screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The results of said screenings shall be provided to TennCare on a monthly basis. The word "contractors" in this section shall refer to all individuals listed on the disclosure form including providers and non-providers such as board members, owners, agents, managing employees, etc.
- A.30.e. The Contractor and its subcontractors and Providers agree to disclose business transaction information upon request and as otherwise specified in federal and state regulations.
- A.30.f. The Contractor shall not have:
1. A director, officer, or partner who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
 2. A person with ownership of 5% or more of the Contractor's equity who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
 3. A network provider who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
 4. An employment, consulting, or other agreement for the provision of Contractor contract items or services with a person who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- A.30.g. The Contractor shall provide written disclosure of any:

1. Director, officer, or partner who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No.12549.
2. Subcontractor of the Contractor who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
3. Person with ownership of 5% or more of the Contractor's equity who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
4. Network provider who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
5. Employment, consulting, or other agreement for the provision of CONTRACTOR contract items or services with a person who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
6. An individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

A.30.h. The Contractor and subcontractors shall disclose to the state any persons or corporations with an ownership or control interest in the Contractor that:

1. Has direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Contractor's equity;
2. Owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least 5% of the value of the Contractor's assets;
3. Is an officer or director of an Contractor organized as a corporation; or
4. Is a partner in a Contractor organized as a partnership.

A.30.i. The Contractors and subcontractors shall disclose information on individuals or corporations with an ownership or control interest in the Contractor to the state at the following times:

1. When the Contractor submits a proposal in accordance with the state's procurement process.
2. When the Contractor executes a contract with the state.
3. When the state renews or extends the contract with the Contractor.
4. Within 35 days after any change in ownership of the Contractor.

- A.30.j. The State shall review the ownership and control disclosures submitted by the Contractor and any of the Contractor's subcontractors.
- A.31. Disaster Preparedness and Recovery at the Contractor's Central Claims Processing Site (DPRCCPS) Plan. A single DPRCCPS Plan may be utilized for the TennCare, CoverRx and CoverKids Programs provided the plan meets all needs of each of these TennCare PBM Programs. The Contractor shall submit the Contractor's DPRCCPS Plan to TennCare for review and approval no later than thirty (30) days prior to commencement of claims processing for any of the TennCare PBM Programs, and annually thereafter on the anniversary date of the start of claims processing by the Contractor. If requested, test results of the DPRCCPS Plan shall be made available to TennCare. The DPRCCPS Plan shall be able to meet the requirements of any applicable State and federal regulations, TennCare and the State of Tennessee Strategic Technology Solutions (STS).
- A.31.a. Beginning on the Effective Date of this Contract and during the development of the Information Security Plan, a Contractor representative shall work in conjunction with a team member from both STS and TennCare's Medicaid Management Information System (MMIS) to ensure that the DPRCCPS Plan is compatible with MMIS, and TennCare, CoverRx and CoverKids policy and procedures and/or rules.
- A.31.b. The Contractor shall include sufficient information in the DPRCCPS Plan to show that it meets the following requirements:
1. Documentation of emergency procedures that include steps to take in the event of a natural disaster by fire, water damage, sabotage, mob action, bomb threats, etc. This documentation shall be in the form of a formal disaster recovery plan. The Contractor shall apply recognized industry standards governing disaster preparedness and recovery including the ability to continue processing claims in the event the Central Claims Processing Site is rendered inoperable.
 2. Employees at the Central Claims Processing Site shall be familiar with the emergency procedures.
 3. Smoking shall be prohibited at the Central Claims Processing Site.
 4. Heat and smoke detectors shall be installed at the Central Claims Processing Site both in the ceiling and under raised floors (if applicable). These devices shall alert the local fire department as well as internal personnel.
 5. Portable fire extinguishers shall be located in strategic and accessible areas of the Central Claims Processing Site. They shall be vividly marked and periodically tested.
 6. The Central Claims Processing Site shall be protected by an automatic fire suppressing system.
 7. The Central Claims Processing Site shall be backed up by an uninterruptible power source system.
- A.31.c. The Central Claims Processing Site Plan shall also describe the Contractor's secondary processing site (Secondary Processing Site) and how quickly Point of Sale (POS) operations for all TennCare PBM Programs can be transferred to the Secondary Processing Site. If claims processing is transferred to the Secondary Processing Site, TennCare shall have direct, "read only" access to the secondary site's systems allowing designated TennCare staff to review the accuracy of each TennCare PBM Program's data on the Contractor's system located at the Secondary Processing Site. The Secondary Processing Site shall be located within the continental United States.
- A.32. Business Continuity and Contingency (BCCP) Plan – Disaster Recovery, System Back-up. A

single BCCP Plan – Disaster Recovery and System Backup Plan may be utilized for the TennCare, CoverRx and CoverKids Programs, provided the BCCP Plan meets all needs of each TennCare PBM Program. These plans shall comply with the following:

- A.32.a. BCCP Plan. The Contractor shall deliver a preliminary BCCP Plan during the Transition and Implementation activities for TennCare's review and approval, and shall update and test this BCCP Plan as directed by TennCare. The BCCP Plan shall be in accordance with State standards as established by the Tennessee Emergency Management Agency (TEMA) for Continuity of Operations Plan documentation. The BCCP Plan shall establish adequate backup processes for all TennCare PBM Programs systems and operational functions and address the potential impacts of disaster occurrence. The contingency section of the BCCP Plan shall satisfactorily address fundamental operations for system back-up (Systems Back-up Plan) and disaster recovery (Disaster Recovery Plan).
- A.32.b. System Back-up and Disaster Recovery Contractor Requirements:
1. The Contractor shall establish and maintain daily back-ups that are adequate and secure for all computer software and operating programs, databases, files, and systems, operations, and user documentation (in electronic and non-electronic form) that are updated on a daily basis.
 2. The Contractor shall establish and maintain a weekly back-up that is adequate and secure for all computer software and operating programs, databases, files, and systems, operations, and user documentation (in electronic and non-electronic form).
 3. The Contractor shall develop a plan for physical and system security that shall identify all potential security hazards at the physical Central Claims Processing Site, including systems and networks, and shall identify the associated protection plans for the system assets and controls.
 4. The Contractor shall participate in the creation, updating and maintenance of the State Security Plan (SSP) as required. In addition, the Contractor shall participate in, and support as needed, any security related meetings, information requests and documentation requested by CMS or other State Agencies.
 5. The Contractor shall follow all applicable technical standards for site and system security during the operation of the system, using best practices as developed by the National Institute of Standards and Technology (NIST) and in alignment with TennCare policy.
 6. The Contractor shall provide for off-site storage of back-up operating instructions, procedures, reference files, systems documentation, programs, procedures, and operational files. Procedures shall be specified for updating off-site materials.
 7. The Contractor shall establish and maintain complete daily back-ups of all data and software and support the immediate restoration and recovery of lost or corrupted data or software.
 8. Prior to beginning any TennCare PBM Program system operations work, the Contractor shall submit for TennCare's approval the BCCP and internal procedures to implement it. TennCare in its sole discretion shall determine whether the BCCP is adequate or whether revisions are necessary.
 9. The Contractor shall provide for a back-up processing capability at a remote site(s) from the Contractor's Central Claims Processing Site, such that normal payment processing, as well as other system and TennCare, CoverRx and CoverKids services deemed necessary by the State, can continue in the event of a disaster or major hardware problem at the Central Claims Processing Site.

10. All proposed off-site procedures, locations, and protocols shall be approved by the State in advance.
11. The Contractor shall clearly document all of the components and file systems that would be required for a full restore.
12. The Contractor shall document batch processes as to sender, receiver, location, process, date and databases updated and have a plan that details how each batch process would be supported and carried out to achieve a full restore.
13. In the event of a disaster, the Contractor shall specify the respective time frames deemed reasonably necessary for complete recovery, as approved by TennCare.
14. The recovery period for the Central Claims Processing Site, in the event of a catastrophic disaster, shall not exceed thirty (30) calendar days.
15. The recovery period for the Central Claims Processing Site, in the event of a disaster caused by criminal acts or natural disasters, shall not exceed ten (10) calendar days.
16. The Contractor shall take all steps necessary to fully recover the data and/or system from the effects of a disaster and to reasonably minimize the recovery period.
17. The Contractor shall perform back-up demonstrations at no additional cost to the State. Failure to successfully demonstrate the procedures may be considered grounds for termination of this Contract. The State reserves the right to waive part or all of the demonstrations. In the event the Contractor's test is deemed by the State to be unsuccessful, the Contractor shall continue to perform the test until satisfactory, at no additional cost.
18. The Contractor shall develop a BCCP Plan that identifies the core business processes involved in the system.
19. The BCCP Plan shall be available to the State at TennCare's main office.
20. The BCCP Plan shall identify potential system failures for each core business process.
21. The BCCP Plan shall contain a risk analysis for each core business process.
22. The BCCP Plan shall contain an impact analysis for each core business process.
23. The BCCP Plan shall contain a definition of minimum acceptable levels of outputs for each core business process.
24. The BCCP Plan shall contain documentation of contingency plans.
25. The BCCP Plan shall contain definition of triggers for activating contingency plans.
26. The BCCP Plan shall contain discussion of establishment of a business resumption team.
27. The BCCP Plan shall address maintenance of updated disaster recovery plans and procedures.
28. The BCCP Plan shall address planning for replacement of personnel to include:
 - (a) Replacement in the event of loss of personnel before or after signing this Contract;

- (b) Replacement in the event of inability by personnel to meet performance standards;
 - (c) Allocation of additional resources in the event of the Contractor's inability to meet performance standards;
 - (d) Replacement/addition of personnel with specific qualifications;
 - (e) Time frames necessary for replacement;
 - (f) Contractor's capability of providing replacements/additions with comparable experience; and
 - (g) Methods for ensuring timely productivity from replacements/additions.
29. The system shall maintain appropriate checkpoint/restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications for voice and data circuits, and disaster recovery.
30. The Contractor shall be required to prepare and maintain a Disaster Recovery Plan as part of the BCCP Plan and provide TennCare with up-to-date copies at least once a year during the term of this Contract. The Disaster Recovery Plan shall be submitted to TennCare for approval prior to the systems implementation and whenever changes are required.
31. The Contractor shall ensure that each aspect of the Disaster Recovery Plan is detailed as to both Contractor and TennCare responsibilities and shall satisfy all requirements for federal certification. Normal TennCare PBM Program related day-to-day activities and services shall be resumed within five (5) working days of the inoperable condition at Central Claims Processing Site.
32. The Contractor shall dedicate two (2) Subject Matter Experts (SMEs) to be onsite to participate in the disaster recovery drills.
33. The Contractor shall coordinate with the State to demonstrate any near real-time failover capabilities in the primary data center or between primary and backup data centers in support of business continuity requirements. Failure to successfully demonstrate failover capabilities may be considered grounds for termination of this Contract. The State reserves the right to waive part or all of the demonstrations. In the event the Contractor's test is deemed by the State to be unsuccessful, the Contractor shall continue to perform the test and implement any changes necessary until satisfactory to the State, at no additional cost to the State.
34. The Disaster Recovery Plan shall address checkpoint/restart capabilities.
35. The Disaster Recovery Plan shall address retention and storage of backup files and software.
36. The Disaster Recovery Plan shall address hardware backup for the main processor(s).
37. The Disaster Recovery Plan shall address network backup for voice and data telecommunications circuits.
38. The Disaster Recovery Plan shall address Contractor provided voice and data telecommunications equipment.
39. The Disaster Recovery Plan shall address the Uninterruptible Power Source (UPS) at both the primary and alternate sites with the capacity to support the system and its

components;

40. The Disaster Recovery Plan shall address the continued processing of TennCare, CoverRx and CoverKids transactions (claims, eligibility, provider file, and other transaction types), assuming the loss of the Contractor's Central Claims Processing Site. This shall include interim support for the TennCare and CoverKids online component of the MMIS and how quickly recovery may be accomplished.
41. The Disaster Recovery Plan shall address back-up procedures and support to accommodate the loss of online communication between the Contractor's Central Claims Processing Site and the State.
42. The Disaster Recovery Plan shall contain detailed file back-up plan and procedures, including the off-site storage of crucial transaction and master files. The plan and procedures shall include a detailed frequency schedule for backing up critical files and (if appropriate to the back-up media) their rotation to an off-site storage facility. The off-site storage facility shall provide security of the data stored there, including protections against unauthorized access or disclosure of the information, fire, sabotage, and environmental considerations.
43. The Disaster Recovery Plan shall address the maintenance of current system documentation and source program libraries at an off-site location.
44. The Contractor shall provide documentation defining back-up processing capacity and availability. Included shall be a prioritized listing of all of the Contractor's back-up processing that shall be performed at the back-up processing facility in the event of an inoperable condition at the Central Claims Processing Site. Estimated back-up processing capacity utilization shall be included for each back-up processing item listed. Documentation shall include written agreements with the management of the back-up processing facility. The agreements shall identify duties and responsibilities of all parties involved, as well as specify the level of back-up service to be provided to the State.
45. The Contractor shall demonstrate the disaster recovery capability for all critical system components at a remote site once during the first year of this Contract and no less often than every two (2) calendar years, in accordance with the 45 CFR §95.621(f). The demonstration at the remote site shall be performed for all administrative, manual, input, processing, and output procedures functions, and include:
 - (a) The processing of one (1) daily and one (1) weekly payment processing cycle, at a minimum;
 - (b) A test of all online transactions;
 - (c) A test of query and reporting capability; and
 - (d) Verification of the results against the corresponding procedures and production runs conducted at the Central Claims Processing Site.

A.32.c. BCCP Plan Deliverables. The Contractor shall provide the following BCCP Plan Deliverables:

1. Submit BCCP and Disaster Recovery Plans to TennCare at least sixty (60) days prior to Go Live for any of the TennCare PBM Programs.
2. Submit a Security Plan within thirty (30) calendar days of the Effective Date of the Contract. The Security Plan shall be reviewed annually and updated as needed or anytime there is a major system change.

- A.33. Problem Notification. At the point at which the Contractor discovers or reasonably should have known of any problem that is reasonably likely to jeopardize the Contractor's ability to perform any function required under this Contract, the Contractor shall notify the applicable State staff (as well as the State's designated general contact for this Contract) in person, via phone, or by email within one (1) hour if the problem is discovered within the business day or no later than 9:00 a.m. CT the following business day if the problem occurs after close of business.
- A.33.a. Corrective Action Plan. Unless otherwise directed by the State, the Contractor shall within three (3) business days of a problem's occurrence deliver comprehensive written documentation, including a Corrective Action Plan that describes how the Contractor shall determine the root cause of the issue, remedy the immediate operational challenges, and prevent this or similar problems from occurring again.
- A.33.b. Complaint Notification. Unless otherwise directed in writing by the State, the Contractor shall report to the State within one (1) business day of receipt, any complaints from pharmacies, providers, or any other party with access to the Contractor's systems regarding the Contractor's technology, communications issues, data inaccuracy, or other related performance problems.
- A.34. Breach. For purposes of this Contract, the following events shall hereinafter be referred to as a "Breach" and the Contractor shall be deemed to have breached the Contract if any of the following occurs:
- A.34.a. A failure to perform in accordance with any material term or provision of the Contract;
- A.34.b. Any act prohibited or restricted by the Contract; or
- A.34.c. Violation of any warranty set forth in the Contract.

The State shall notify Contractor in writing of a Breach, and the State shall have available the remedy of Liquidated Damages, as provided in Attachment C, or Actual Damages, and any other remedy available at law or equity.

- A.35. Partial Default. In the event of a Breach, the State may declare a partial default. In which case, the State shall provide the Contractor written notice of: (1) the date on which Contractor shall terminate providing the service associated with the Breach; and (2) the date the State will begin to provide the service associated with the Breach. Notwithstanding the foregoing, the State may revise the time periods contained in the written notice to the Contractor.

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

Upon partial default, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount. Contractor agrees to cooperate fully with the State in the event a partial default is taken.

- A.36. Transition of TennCare PBM Program Services to Successor PBM. Contractor agrees to comply with the following requirements at the termination, for any reason, of this Contract to ensure a seamless transition of services from the Contractor to the State's successor PBM contractor (Successor PBM). Unless otherwise specified in writing by the State, all provisions of this Contract shall apply during the transition period. Contractor shall cooperate with the State and the Successor PBM to create and implement a transition plan and calendar of events that will ensure a comprehensive transfer of Contractor's PBM services to the

Successor PBM. The State, in its sole discretion, will determine the termination date of this Contract. During the transition period, Contractor shall continue to provide all services and meet all performance metrics required in this Contract until all PBM services have been successfully transferred to the Successor PBM at Go Live of each of the TennCare PBM Programs to be handled by the Successor PBM. The transition period shall include up to thirty (30) calendar days following Go Live of each TennCare PBM Program, as needed, to finalize successful transfer of data and documentation to the Successor PBM. Other than the monthly Administrative Fees and any permitted pass through expenses payable to the Contractor pursuant to Section C, the Contractor shall not receive any additional compensation for its services during the transition period, including any services provided following Go Live of the TennCare PBM Programs.

- A.37. Exigency Extension. At the option of the State, the Contractor agrees to continue services under this Contract when the State determines that there is a public exigency requiring the services to continue beyond the contract term end date. Continuation of services pursuant to this Section shall be in three (3) month increments and the total of all public exigency extensions shall not exceed twelve (12) months. Thirty (30) calendar days written notice shall be given to the Contractor by the State before this option is exercised. A written notice of exigency shall constitute an executed amendment revising the maximum liability and contract end date and other adjustments permitted under Section C. This amendment shall be approved by the Central Procurement Office (CPO) and the Tennessee Office of the Comptroller of the Treasury.
- A.38. Partial Performance. The parties agree that a range of performance outcomes is likely for the deliverables in this Contract. The State shall, in its sole discretion, make the determination of whether the Contractor's performance is timely and satisfactory with regard to a given deliverable.
- A.39. Performance Guarantee. The State will pay the Contractor a separate monthly Administrative Fee for each TennCare PBM Program, as specified in Section C.3 (and as submitted in Contractor's RFP Cost Proposal). To guarantee Contractor's satisfactory and timely performance of the services and deliverables set forth in this Contract (Performance Guarantee), payment of up to twenty percent (20%) of the total monthly Administrative Fee for each TennCare PBM Program shall be based solely on Contractor's ability to satisfactorily perform specific metrics selected for each PBM Program by the State from all of the Contractor services and deliverables set forth in this Contract. Attachment G to this Contract contains specific performance requirements for each of the TennCare PBM Programs that have been selected by the State to be the initial performance deliverables to be used with each TennCare PBM Program. The State may, in its sole discretion and upon thirty (30) days prior written notice, select any other services or deliverables required in the Contract to use for determining the amount of Administrative Fee to be paid by the State each month for each TennCare PBM Program. In addition to selecting different performance metrics, the State may also use this thirty (30) day notice to change the weight of the selected performance metrics to be higher or lower than the weights currently shown in Attachment G.
- Following Go Live for each TennCare PBM Program, the State will use the Control Memorandum Process described in Section A.5 to implement the Performance Guarantee measures for each of the TennCare PBM Programs. Each Control Directive implementing the Performance Guarantee for a particular TennCare PBM Program may designate up to six (6) Contract services, deliverables or categories of deliverables to be used as performance metrics and shall stipulate for each metric the performance parameters and requirements for Contractor's performance to be considered acceptable, and the level of performance below which the State deems performance to be unacceptable. The outcome of Contractor's efforts each month with regard to each performance metric shall be determined on a pass/fail basis by reference to the specific numerical performance requirement or completion of specific tasks as set forth in the Control Directive. The Control Directive shall also include any specific reporting requirements and the length of time the specified metrics will be used to determine the amount of monthly TennCare PBM Program Administrative Fees to be paid for each TennCare PBM Program. Based on the results of Contractor's efforts each month in which the Performance Guarantee is in effect, the State will pay the Contractor, at the same time

the rest of the monthly Administrative Fee for that particular TennCare PBM Program is paid, the applicable portion of the monthly Administrative Fee that corresponds with the Contractor's successful performance of the designated metrics. If the Contractor fails to meet some or all of the performance requirements set forth in the Control Directive for a particular month, the State shall permanently withhold the applicable portion of the monthly Administrative Fee when the State pays the Contractor the remainder of that month's Administrative Fee for each TennCare PBM Program.

The State, in its sole discretion, may elect to implement a Performance Guarantee measure for a particular TennCare PBM Program on a test basis to verify the measure is working as intended before using that performance measure to actually determine Administrative Fee payment. If the State elects to use a Performance Guarantee test, the applicable Control Directive will indicate that a test period is to be used for a specified performance measure and the Contractor shall be required to adhere to the specifications in the Control Directive as if the performance measure being tested was actually being used to determine monthly Administrative Fee payment. However, the Pass/Fail outcome of Contractor's compliance with the test performance measures shall not be used by the State to withhold any part of a related monthly Administrative Fee during a test of a performance metric.

Using the performance metrics set forth in Attachment G, illustrations of performance metrics used to determine Performance Guarantee efforts, and sample calculations of the effect of the performance metrics on payments of monthly Administrative Fees for each TennCare PBM Program are shown below in Contract Section A.52 for the TennCare PBM Program, Section A.62 for the CoverRx PBM Program and Section A.82 for the CoverKids PBM Program, respectively. The information shown in these illustrations and the outcomes shown for each metric are only examples, and shall not be deemed to revise or amend any provision of this Contract.

A.40. The Contractor shall comply with the following requirements while providing services to the TennCare PBM Programs:

A.40.a. Cost Sharing.

Any cost sharing imposed on Medicaid enrollees shall be in accordance with requirements at 42 C.F.R. §§ 447.50 through 42 CFR 447.82. The Contractor and all providers and subcontractors shall not require any cost sharing or patient liability responsibilities for covered services except to the extent that cost sharing or patient liability responsibilities are required for those services by TennCare in accordance with TennCare rules and regulations, including but not limited to, holding enrollees liable for debt due to insolvency of the Contractor or non-payment by the State to the Contractor.

A.40.b. Independent Review of the Contractor.

The Contractor shall cooperate fully with TennCare's External Quality Review Organization (EQRO) which will conduct a periodic and/or an annual independent review of the Contractor. The Contractor shall cooperate fully with any evaluation of the TennCare program conducted by CMS.

A.40.c. Parity in Mental Health and Substance Use Disorder Benefits

The Contractor shall require that prior authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d).

A.40.d. Utilization Management.

The Contractor shall assure, consistent with 42 CFR 438.6(h), 42 CFR 422.208 and 422.210, that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.

A.40.e. Independent Accrediting Entity.

The Contractor shall inform the State as to whether it has been accredited by a private independent accrediting entity. If the Contractor receives accreditation by a private independent accrediting entity, then the Contractor shall authorize the private independent accrediting entity to provide the State a copy of its most recent accreditation review, including:

1. Its accreditation status, survey type, and level (as applicable);
2. Recommended actions or improvements, corrective action plans, and summaries of findings; and
3. The expiration date of the accreditation.

A.40.f. Availability and Accessibility of Services

The Contractor shall submit documentation on which the state bases its certification that the Contractor complied with the state's requirements for availability and accessibility of services, including the adequacy of the provider network.

The Contractor shall submit any other data, documentation, or information relating to the performance of the Contractor's obligations as required by the State or Secretary.

The individual who submits data to the State showing compliance with the State's requirements for availability and accessibility of services shall provide a certification, which attests, based on best information, knowledge and belief that the data, documentation and information are accurate, complete and truthful.

Any data, documents, information, or reports that the Contractor provides to the State under this Contract shall be accompanied by a certification that the same are accurate, complete, and truthful to the best knowledge, information, and belief of the certifying authority. Only the following individuals may make such certification:

1. The Contractor's Chief Executive Officer (CEO).
2. The Contractor's Chief Financial Officer (CFO).
3. An individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

The Contractor shall submit certification concurrently with the submission to TennCare of data, documentation, or information.

The state retains authority pursuant to 42 C.F.R. 438.702 to impose additional sanctions under State statutes and State regulations that address areas of noncompliance.

TennCare enrollees shall not be liable for the Contractor's debts in the event the Contractor becomes insolvent. The Contractor shall provide assurances satisfactory to the state that its provision against the risk of insolvency is adequate to ensure that Enrollees will not be liable for the Contractor's debt if the Contractor becomes insolvent.

Enrollees shall not be liable for covered services provided to the enrollee, for which the state does not pay the Contractor, or for which the state or the Contractor does not pay the provider that furnished the service under a contractual, referral, or other arrangement.

Enrollees shall not be held liable for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the enrollee would owe if the Contractor covered the services directly.

The Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data.

The Contractor shall comply with Section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of section 1903(r)(1)(F) of the Act.

The Contractor shall collect data on enrollee and provider characteristics as specified by the state and on all services furnished to enrollees through an encounter data system or other methods as may be specified by the state.

The Contractor shall screen the data received from providers for completeness, logic, and consistency.

The Contractor shall collect data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for the state's quality improvement and care coordination efforts.

A. 40.g The Contractor shall make all collected data available to the state and upon request to CMS. The contractor shall provide:

1. Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.
2. enrollee encounter data to the state at a frequency and level of detail to be specified by CMS and the state, based on program administration, oversight, and program integrity needs.
3. all enrollee encounter data that the state is required to report to CMS.
4. Specifications for submitting encounter data to the state in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, and the NCPDP Post Adjudication Standard 4.5 format shall be used for encounter reporting sent to the State.

No payment shall be made to a network provider other than by the Contractor for services covered under the contract between the state and the Contractor, except when these payments are specifically required to be made by the state in Title XIX of the Act, in 42 CFR, or when the state makes direct payments to network providers for graduate medical education costs approved under the state plan.

A.40.h. The State shall collect the following information from the Contractor to improve the performance of its PBM program:

1. Enrollment and disenrollment data from the Contractor.
2. Member grievance and appeal logs from the Contractor.

The State shall collect provider complaint and appeal logs from the Contractor to improve the performance of its PBM program.

Should the State learn that the Contractor has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the Contractor has relationship with an individual who is an affiliate of such an individual, the state may continue an existing agreement with the Contractor unless the Secretary directs otherwise.

Should the State learn that the Contractor has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act, the state may continue an existing agreement with the Contractor unless the Secretary directs otherwise.

Should the state learn that a Contractor has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the Contractor has relationship with an individual who is an affiliate of such an individual, the state may not renew or extend the existing agreement with the Contractor unless the Secretary provides to the state and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

Should the state learn that the Contractor has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act, the state may not renew or extend the existing agreement with the Contractor unless the Secretary provides to the state and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

The State shall screen and enroll, and periodically revalidate all Contractor network providers as Medicaid providers.

The Contractor may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider, and notify affected enrollees.

TennCare Pharmacy Services

A.41. TennCare Services Implementation Plan

A.41.a. TennCare Services Implementation Plan Overview. Implementation of the TennCare Program portion of this Contract shall be conducted as series of defined phases described below, with the date for Go Live, on which the Contractor is to assume full responsibility for operation of TennCare Program, January 1, 2020. The Contractor shall be required to complete all the tasks, obligations and responsibilities listed under each phase by the dates identified in the TennCare Project Plan which shall be developed by the Contractor and an implementation contractor procured by the State (Implementation Contractor) and submitted to the State for review and approval in accordance with the TennCare Services Plan Implementation Schedule. The TennCare Project Plan shall be prepared using Microsoft Project or such other program as the State may direct, and shall include a detailed timeline description of all work to be performed both by the Contractor, Implementation Contractor and the State. The TennCare Project Plan shall also include a description of the participants on the Contractor's, Implementation Contractor's and the State's transition teams and their roles and schedules of meetings.

A.41.b. CMS Certification of Contractor's TennCare PBM System to Qualify for Enhanced Federal Financial Participation (EFTP) Funding. In order to maximize the EFTP match for the TennCare PBM Program, TennCare requires the Contractor's PBM System (TennCare PBM System) to be certified by CMS. The Contractor shall provide specific artifacts and documentation to TennCare, in accordance with the criteria established in the Medicaid Enterprise Certification Toolkit (MECT) appendix B Required Artifact list, Pharmacy Checklist, the five core technical checklists, and timelines delineated in the Medicaid Enterprise

Certification Toolkit, as evidence that the TennCare PBM System meets CMS' certification requirements through every SDLC phase. Following the TennCare Program Go Live on January 1, 2020, the TennCare PBM System will be evaluated for certification by CMS using the agreed upon version of the MECT (currently MECT 2.2). CMS requires the TennCare PBM System to be in production for six (6) months prior to submission of TennCare's initial certification request, which is anticipated to be submitted to CMS on July 1, 2020. The Contractor shall provide, no later than December 1, 2019, all finalized TennCare PBM System artifacts and documentation that CMS requires. For vendors who have successfully completed CMS pre-certification of their PBM system, Section A.41.b.1, Section A.41.b.2, Section A.41.b.3, Section A.41.b.4, and Section A.41.b.5 shall be required as applicable.

1. The Contractor shall provide a mapping of the system functionality to MECT 2.2. or current agreed upon version of Pharmacy Checklist and Technical Checklists

The withholds of the Contractor's monthly Administrative Fee related to the TennCare PBM Program set forth in this Section A.41.b are separate from, and in addition to, the Section A.52 TennCare Program Performance Guarantee withholds, and the Section A.53 TennCare Program PBM Risk Sharing Module withholds.

Prior to TennCare PBM Program Go Live, the State and Contractor shall enter into an Administrative and Escrow Agreement (Administrative and Escrow Agreement) regarding this Section A.41.b. Refer to Attachment I for Sample Escrow Agreement template, with final document to be determined by TennCare. Execution of the Administrative and Escrow Agreement shall be a Readiness Review requirement to obtain TennCare's approval for the Contractor to proceed with TennCare PBM Program Go Live.

2. **Withhold Upon Timely Submission to TennCare of TennCare PBM System Artifacts and Documentation.** Beginning July 1, 2020, the State shall withhold seven and one half percent (7.5%) of the Contractor's monthly Administrative Fee related to the TennCare PBM Program each month or part of a month until the TennCare PBM System has been successfully certified by CMS. Provided the Contractor made timely submission to TennCare of all TennCare PBM System artifacts and documentation required to allow TennCare to submit its initial system certification request to CMS by July 1, 2020. , upon receipt of written notice from CMS that the TennCare PBM System is successfully certified, TennCare shall return all withhold amounts held pursuant to this Section A.41.b.1 to the Contractor as set forth in Section A.41.b.4.
3. **Permanent Withhold for Failure to Make Timely Submission of TennCare PBM System Artifacts and Documentation to TennCare.** If the Contractor fails to provide the necessary TennCare PBM System artifacts and documentation by December 1, 2019, the State shall permanently withhold seven and one half percent (7.5%) of the Contractor's monthly Administrative Fee related to the TennCare PBM Program beginning on December 1, 2019, and continuing each month or part of a month until the necessary TennCare PBM System artifacts and documentation have been provided. The State shall keep any such permanent monthly withholds that occur during the period of time beginning December 1, 2019 and continuing each month or part of a month until the necessary artifacts and documentation have been provided.
4. **Increased Withhold Due to CMS Corrective Action Notice(s).** Following TennCare's initial system certification request to CMS, if CMS identifies and requests corrective action as a result of its review of the TennCare PBM System, the Contractor shall have sixty (60) calendar days from the date CMS provides the written corrective action notice to the State to perform all requirements of the corrective action and provide any required artifacts and/or documentation to TennCare. The Contractor shall perform this work at no additional cost to the State. TennCare shall provide Contractor with a copy of CMS' written corrective action notice within three (3) business days of receiving it. Upon receipt from the Contractor of the required evidence that the Contractor has complied with CMS' corrective action request, TennCare shall resubmit its system certification request to CMS with the evidence

that the corrective actions in connection with the TennCare PBM System have been successfully completed by Contractor. Upon review of the State's resubmitted systems certification request, if CMS determines there are additional corrective actions needed in order to certify the TennCare PBM System, the State shall notify Contractor upon receipt of CMS' supplemental corrective action request pursuant to Section A.41.b.3, and this process shall be repeated, as needed, until the TennCare PBM System is certified by CMS.

If the Contractor fails to provide the necessary artifacts and documentation, or fails to begin or complete the corrective action(s) by the sixtieth (60th) day from the date the initial corrective action was requested by CMS, the State shall, on the sixty-first (61st) day from the date the initial corrective action was requested by CMS, increase the monthly withhold from seven and one half percent (7.5%) of the Contractor's monthly Administrative Fee related to the TennCare PBM Program to twelve and one half percent (12.5%), as a permanent withhold. Such twelve and one half percent (12.5%) permanent withhold shall continue each month or part of a month until CMS notifies the State in writing that the corrective action(s) relating to the TennCare PBM System have been successfully mitigated. At that time, if CMS does not simultaneously confirm that the Contractor's corrective actions have been accepted and provide written confirmation that the TennCare PBM System is certified to receive EFFF, the monthly withhold shall decrease to seven and one half percent (7.5%) of the Contractor's monthly Administrative Fee related to the TennCare PBM Program, to be withheld each month or part of a month until the State receives written confirmation from CMS that the TennCare PBM System has been certified.

Upon receiving CMS certification, the State shall keep the full amount of any twelve and one half percent (12.5%) permanent monthly withhold that occurs during the period of time identified above beginning with the sixty-first (61st) day following the date the initial corrective action was requested by CMS and ending on the date the State receives written confirmation from CMS that the Contractor's corrective action(s) have been accepted by CMS. Such twelve and one half percent (12.5%) permanent monthly withhold funds shall be in addition to any permanent seven and one half percent (7.5%) withholds kept by the State pursuant to Section A.41.b.2. If, during the period of time beginning with the date the State receives written confirmation that CMS has accepted all of the Contractor's corrective actions and ending on the date the State receives written confirmation from CMS that the TennCare PBM System is certified, the State made any seven and one half percent (7.5%) withholds from the Contractor's monthly Administrative Fee related to the TennCare PBM Program, these withholds shall be paid to the Contractor pursuant to Section A.41.b.4.

5. The State may simultaneously withhold funds from Contractor's monthly Administrative Fee related to the TennCare PBM Program pursuant to Sections A.41.b.1 through A.41.b.3 pursuant to the terms thereof. When TennCare receives written confirmation from CMS that certification of the TennCare PBM System has been achieved, the State will provide a copy of the written certification notice to the Contractor within five (5) business days of receipt from CMS, and release any Administrative Fees held pursuant to Sections A.41.b.1 through A.41.b.3, that have not been forfeited to the State, with such funds to be included in the next monthly Administrative Fee payable to Contractor.
6. If CMS does not certify the TennCare PBM System prior to the end of the Contract, but the State, in its sole discretion, determines that the Contractor satisfied all program and technical requirements required for EFFF, the State shall release to Contractor all remaining funds withheld from Contractor's monthly Administrative Fee related to the TennCare PBM Program that were not permanently forfeited to the State pursuant to Sections A.41.b.2. and A.41.b.3. If released, such funds will be included in the next monthly Administrative Fee payable to Contractor.

A.41.c. TennCare Project Initiation and Requirements Definition Phase. The State shall conduct a project kick-off meeting, which all Contractor Key Staff and project staff shall attend. TennCare project staff shall provide access and orientation to the TennCare Pharmacy Program and system documentation. TennCare technical staff shall provide an overview of the Tennessee MMIS emphasizing pharmacy claims processing and adjudication, reference files, and payment processes. During this phase the Contractor shall develop the documentation identified below and submit it to the State for review and approval accordance with the TennCare Services Implementation Plan Schedule. The Contractor shall not proceed to the subsequent phase without receiving said approval of the documentation identified below:

1. Functional and Informational Requirements (FIR) Document. This document shall include detailed requirements for both internal and external interfaces and all TennCare Point-of-Sale (POS) functionalities required by the RFP and/or contained in the Contractor's proposal and/or this Contract. Eligibility interfaces with the State are critical and the Contractor is required to be in sync with the State's MMIS eligibility data. All outbound "834 Files" from TennCare shall be loaded to the Contractor's data base within twenty-four (24) hours of receipt from TennCare. This requirement includes any "834 Transactions" that must be handled manually by the Contractor. The Contractor shall be required to submit weekly eligibility/enrollment reports to the State which will be defined during the Design, Development, and Implementation (DDI) phases. These reports shall provide weekly counts of enrollment by eligibility categories, benefit categories and any other category determined by the State. If the counts do not reconcile with the MMIS eligibility and enrollment counts, the Contractor shall be required to research the discrepancies to explain the differences to the State. Discrepancies shall be resolved within five (5) business days. Differences that are not resolved within five (5) business days shall require the Contractor to deliver a corrective action plan to the State within forty-eight (48) hours of the end of the five (5) business day period.
2. Data Dictionary. For each data field this shall indicate content, size, values, structure, edit criteria and purpose.
3. Data Mapping. This shall consist of a cross-reference map of required MMIS data and TennCare POS data elements and data structures. A separate data structure map shall be required for each transaction and interface. A data conversion plan, that includes both automated and manual activities, shall be provided for each data structure map. The State shall make any necessary data formats available to the Contractor.
4. Suggested MMIS Modifications. The Contractor shall recommend any design modifications to the MMIS that it determines are suggested or necessary relating to the TennCare PBM services. Performing any modifications, maintenance and design enhancements to MMIS shall be the sole decision and responsibility of the State.
5. A Change Management Plan shall be developed by the Contractor. This plan shall, at a minimum, contain the following information:
 - (a) Identification of a change control board along with primary and backup members assigned
 - (b) Categorization of change types (e.g., standard, emergency, etc.)
 - (c) Process for requesting, tracking, and performing impact analyses for each change request
 - (d) Process for deciding whether to approve changes and for verifying that changes were made correctly

6. A Privacy Impact Analysis shall be developed by the Contractor. This plan shall, at a minimum, contain the following information:
 - (a) Use of personally identifiable information (PII) or personal health information (PHI) and a description of the types of data that will be collected
 - (b) Sources of PII/PHI, populations, and transfer and disclosure mechanisms
 - (c) Legal environment (legal authorities and state privacy laws)
 - (d) Details about the entities with which the collected information will be shared
 - (e) Privacy and security standards for its business partners and other third parties and the agreements that bind these entities
 - (f) Incident handling procedures
 - (g) Privacy and/or security awareness programs and materials for its workforce
7. Medicaid Information Technology Architecture (MITA) Maturity Assessment. The Contractor shall work with TennCare project staff to assess the MITA maturity gains expected from the implementation of the system, and the Contractor shall work with the State in their effort to complete, and submit to CMS, their MITA State Self-Assessment Scorecard.

A.41.d. TennCare System Analysis/General Design Phase. After approval of the documentation by the State required in the Project Initiation and Requirements Definition Phase, the Contractor shall develop the General System Design Document and submit it to the State for review and approval in accordance with the TennCare Services Implementation Plan Schedule. The Contractor shall not proceed to the subsequent phase without receiving said approval.

The General System Design Document shall include the following information:

1. An Operational Impact Analysis that details the procedures and infrastructure required to enable MMIS, the Contractor's system, and the "switch" systems used by pharmacy providers to work effectively together.
2. A Detailed Conversion Plan that specifies plans for conversion of fifteen (15) months of MMIS and the previous PBM contractor/processor's claims history, provider, recipient, preferred drug list, prior authorization, lock-in and reference data, to be handled through existing CTX extract process format to requiring modifications to MMIS.
3. A Software Release Plan that sets forth the project's implementation into production. This document shall explain procedures for coordinating system changes that shall have an operational or information impact on TennCare POS operations. It shall detail how TennCare POS and/or MMIS software releases are tested and coordinated. The plan shall include both initial implementation of the TennCare POS system and coordination of software releases between MMIS and TennCare POS.

A.41.e. TennCare Technical Design Phase.

During this phase, detailed specifications shall be developed for conversion and for the interface(s) between the MMIS and the Contractor's system. The Contractor shall develop the documentation and plans identified below and submit them to the State for review and

approval in accordance with the TennCare Services Implementation Plan Schedule. The Contractor shall not proceed to the subsequent phase without receiving said approval:

1. Preliminary System Interface Design Overview Document;
2. Unit Test Plan that includes test data, testing process, and expected results;
3. Back-up and Recovery Plan that includes processes for daily backup and recovery of system information;
4. Final Disaster Recovery Plan;
5. Information Security Plan that includes how the Contractor shall maintain confidentiality of TennCare data. This document shall include a comprehensive Risk Analysis or equivalent Certification as detailed in Section A.44. The Contractor shall create a TennCare System Security Plan (SSP) with controls, based on the TennCare SSP Template found in the Bidder's Library. This must be submitted to TennCare security 60 days prior to scheduled go-live for approval. This SSP shall be reviewed/updated by the vendor at least once every 365 days or anytime there is a major system change. ;
6. System, Integration, and Load and Test Plan; and
7. Final System Interface Design Overview Document to be completed after the Contractor has conducted a review of all previous design documents.

A.41.f. TennCare Development Phase

This phase includes activities that shall lead to the implementation of the TennCare POS System. The Contractor shall develop interface and conversion programs, develop system documentation, and develop Unit Test Plans. All testing shall be conducted in accordance with the TennCare Services Implementation Plan Schedule. Where manual data entry screens are required, the Contractor shall develop these screens. Testing shall be performed on all phases and programs shall be documented. Contractor shall provide TennCare with reports to substantiate and document the testing. These reports shall include number of tests run, number of requirements tested, number of tests passed, number of tests failed, and number of tests retested after initial failure. The Contractor shall maintain an issues log which details any testing failures and includes the resolution for those issues. During final User Acceptance Testing (UAT) with the State, only the State can approve the Contractor's issue resolutions. The Contractor is responsible for system content and the correction of any unacceptable system content, even if system errors were not found during UAT. The Contractor shall perform testing activities that shall include the following:

1. TennCare POS System Test to validate the appropriate adjudication of a claim which shall include a description of the test procedure, expected results, and actual results;
2. Integration Testing shall test external system impacts including provider POS systems, downstream MMIS applications, and all interfaces. It shall include a description of the test procedure, expected results, and actual results;
3. Load and Stress Testing shall include volume and efficiency to ensure that the system is able to process the volume of TennCare pharmacy claims, with a focus on testing volumes equivalent to those handled on the first days of each month. It shall include a description of the test procedure, expected results, and actual results; and
4. Final User Acceptance Testing (UAT).

The Contractor shall not proceed to the subsequent phase without successfully completing

the aforementioned testing activities and receiving approval in writing from TennCare.

A.41.g. TennCare Services Implementation/Operations Phase

During this phase the Contractor, Implementation Contractor and the State shall assess the operational readiness of all required system components including, but not limited to, MMIS, the TennCare POS, and required communications links with the pharmacy "switch" providers. This shall result in the establishment of the operational production environment in which all TennCare pharmacy claims shall be accurately and reliably processed, adjudicated and paid. The State shall have final approval for all elements of the operational production environment. The Contractor shall coordinate with the Implementation Contractor to develop the documentation and deliverables identified below and submit them to the State for review and approval in accordance with the TennCare Services Implementation Plan Schedule. The Contractor shall not proceed to the subsequent phase without receiving said approval. The Contractor shall be responsible for timely submitting the following deliverables:

1. Operations Procedures shall be developed and prepared for all procedures and operations performed by Contractor, including but not be limited to, automated operations, data entry operations, Help Desk operations, prior authorization operations/interfaces, check and remittance fulfillment and member notifications;
2. Production and Report Distribution Schedules shall be developed;
3. Operations Training Plan shall be updated;
4. Training Materials for TennCare staff, pharmacy providers, and other identified stakeholders shall be developed;
5. Training Sessions shall be scheduled and the Contractor shall conduct training sessions for TennCare staff, pharmacy providers, and other identified stakeholders;
6. An Incident Management Plan shall be developed by the Contractor. This plan shall, at a minimum, contain the following information:
 - (a) Definition of what constitutes an incident, incident classifications, severity levels, and target times for resolution
 - (b) Processes for reporting, logging, managing, and tracking incidents to resolution and closure
 - (c) Process for communicating with affected stakeholders
 - (d) Identification of an incident manager
7. A Final Conversion Plan shall be developed by Contractor. This plan shall, at a minimum, contain the following activities and projected dates on which each activity shall occur:
 - (a) Loading fifteen (15) months of claims history from TennCare's outgoing PBM contractor's POS system into the Contractor's TennCare POS system;
 - (b) Migrating current prior authorizations, overrides and grandfather provisions with their end dates into the Contractor's TennCare POS system from TennCare's outgoing PBM contractor's POS system; and
 - (c) Running other conversion programs, performing manual functions, performing quality control, reporting on outcomes, and converting files in preparation for TennCare PBM system operation.

- (cl) Pre-testing of new Provider claims submission systems by allowing Providers to submit direct data entry claims and electronic claims test files that are processed through the TennCare POS adjudication cycle without impact on system data.
8. Final Conversion Activities shall be performed by Contractor pursuant to the approved Final Conversion Plan.

A.41.h. TennCare Readiness Review

The State may conduct a desk review and an on-site review that complies with 42 CFR 438.66(d)(2), (d)(3), and (d)(4) to assess the readiness of the Contractor to effectively administer and provide the services as defined in this Contract. The review may also consist of a walk-through of the Contractor's operations, system demonstrations (including systems connectivity testing), and interviews with the Contractor's staff. The scope of the review may include any and all requirements of this Contract as determined by the State. The Contractor shall complete all implementation actions prior to Go Live date and according to the implementation timeline provided by the Contractor to the State. The Contractor shall receive the State's sign-off that each action has been completed successfully. Demonstration for each action step shall include systems and operational readiness prior to Go Live, which includes system processing of critical interfaces such as eligibility/enrollment (834 Files). Implementation action steps shall include, at a minimum, the following items:

1. Benefit plan designs loaded, operable and tested;
2. Perform comprehensive systems testing (including interface testing with all third parties) and quality assurance audits, with results reported to the State prior to "Go-Live";
3. Eligibility feed formats loaded and tested end to end, including but not limited to, the initial base line eligibility/enrollment population, interim daily eligibility/enrollment, and on/after Go-Live eligibility enrollment population, as applicable;
4. Operable plan for transferring current Help Desk toll-free numbers from current TennCare PBM contractor to the Contractor;
5. Signed agreements for all providers in the TennCare PBM Network;
6. Account management, Help Desk and Prior Authorization staff hired and trained;
7. Established billing/banking requirements;
8. Complete notifications to pharmacies and prescribers regarding change in TennCare PBM contractor;
9. Each component shall be completed by the Contractor by the agreed upon deadline set forth in the State approved TennCare Implementation Plan Schedule. At the State's discretion, implementation action requirements may include other items necessary to meet the claims processing commencement date of January 1, 2020 at 12:01 A.M.CST, and
10. Claims history and existing prior authorizations and overrides shall be successfully migrated to Contractor's TennCare POS system.

A.41.i. Remedies Related to TennCare Implementation Plan and Readiness Review Failure. The Contractor shall produce all required TennCare Implementation Plan and Readiness Review deliverables and complete all activities by the due dates indicated on the TennCare Implementation Plan Schedule, in a timely manner and to the satisfaction of the State. Based on the results of the review activities, The State will issue a letter of findings and, if needed,

will request a corrective action plan from the Contractor. TennCare enrollees may not be enrolled with the Contractor until the State has determined that the Contractor is able to meet the requirements of this Contract. Failure to complete implementation plan and readiness review requirements shall be considered a material breach of this Contract, and the State may initiate the Termination for Cause provisions located in Section D.6 or take such other actions and seek such other remedies as are available to it pursuant to this Contract, or at law, or in equity.

A.41.j. TennCare PBM Services Implementation Plan and Readiness Review Schedule. Within twenty (20) days of the Effective Date of this Contract, the Contractor shall submit a TennCare PBM Services Implementation Plan and Readiness Review Plan (TennCare Services Implementation/Readiness Plan) containing all necessary deliverables and activities with projected dates for delivery and/or completion of these items. Upon approval of the TennCare Project Plan by the State, TennCare will direct the Contractor to begin work on the TennCare Services Implementation/Readiness Plan through a Control Memorandum and Control Directive in which all deliverable and activity due dates match the dates in the approved TennCare Project Plan. The State reserves the right to further revise the due dates for the TennCare Services Implementation/Readiness Plan deliverables and activities and to add additional deliverables and activities, as deemed necessary in the State's sole discretion to be in the best interest of the TennCare Program. Time is of the essence in the satisfactory completion of all TennCare Services Implementation/Readiness Plan deliverables and activities by the due dates contained in the then-current TennCare Project Plan.

A.42. TennCare Point of Sale (POS) System

A.42.a. TennCare POS System Overview

The Contractor shall provide an online pharmacy POS system that can be modified to meet the needs of the State and is designed with attention given to user interface inclusive of ergonomic and other standards concerned with usability (e.g., ISO 9241). Additionally, the system shall: support zoom and pan operations in all screens; support search capability that allows users to utilize filtering functionality; provider data, and prescriber data, must be editable by taxonomy; have no taxonomy that does not have prescriptive authority. The Contractor shall provide system design and modification, development, implementation and operation for the TennCare PBM system. The Contractor's TennCare POS system shall allow it to interface with the existing pharmacy "switch" networks that connect the pharmacy providers with the Contractor's system.

The Contractor shall maintain a separate test environment that exactly mirrors the production environment, except the User Acceptance Test environment shall be separate from the development and SIT environments. TennCare and its designees shall be granted access to this test environment for purposes of quality control and audit functions.

The Contractor shall be responsible for operating the TennCare POS system that automates the entire pharmacy claims processing system for the complete pharmacy benefit for all TennCare enrollees.

The source of the claims shall be Contractor's enrolled network pharmacy providers. The majority of claims shall be submitted through POS telecommunications devices. However, the Contractor shall also process claims on batch electronic media for the Tennessee Department of Health's TennCare pharmacy claims.

A.42.b. TennCare Claim Adjudication Services - General Requirements. This section defines claim adjudication requirements for all TennCare pharmacy claims regardless of source electronic batch and POS claims. The timing of the adjudication shall differentiate POS claims from claims submitted in batch. However, all claims shall be adjudicated through a common set of processing modules. All claims adjudicated as payable shall be for eligible members. Payment will be made to registered providers for approved services in accordance with the TennCare rules, regulations, policy, and guidelines pertinent to pharmacy payments in addition to applicable federal guidelines. All adjudicated claims shall be captured to an encounter file and transferred weekly to the TennCare MMIS by the Contractor. The National Council for Prescription Drug Programs (NCPDP) Post Adjudication Standard (PAS) 4.5 format shall be used for the encounter file. At the direction of the State, the Contractor shall make changes to data elements included on the encounter file with no additional cost to the State.

Pass-Through Costs of Certain Mailings to TennCare Enrollees. The Contractor shall use first class U.S. Postal Service rate to distribute and mail TennCare outputs (hard copy and electronic) as directed by the State, including but not limited to returned claims, enrollee notices, provider bulletins, provider manuals and special mailings, unless otherwise directed by the State. Postage costs incurred by the Contractor for these mailings shall be treated as pass-through costs. Such costs shall be invoiced on a monthly basis to the State in addition to regular invoices and shall include supporting documentation including receipts for services rendered. Pass through costs by nature are not charged to the contract balance, As a result, no other pass through costs are allowed to be charged on the invoice under this category. For example, administrative overhead or other Contractor fees shall not be added to the invoice as pass-through costs.

Cost of Certain Mailing to be Responsibility of Contractor. The Contractor shall mail provider checks and remittance advices, returned claims, notices, provider bulletins, provider manuals and special mailings using first class U.S. Postal Service rate. Postage costs incurred by the Contractor for these mailings shall be treated as pass-through costs. The Contractor shall be responsible for TennCare POS system messages and notice of claims being adjudicated payable, denied or rejected. Claims denied or rejected shall return situation specific messages to assist pharmacies with resubmissions. All printing and supply costs for checks and remittance advices shall be included in the Contractor's monthly Administrative Fee, and shall not be invoiced to the State.

TennCare Weekly Claims Payment Contractor shall comply with the following requirements regarding the payment of weekly claims by TennCare to the Contractor:

1. – The Contractor shall issue payments to Pharmacy Providers each Friday. In order for the State to be able to fund weekly pharmacy provider payments the Contractor must follow a schedule outlined by the TennCare Accounting Office.
2. The Contractor shall deliver the following four (4) files to the State in an electronic media as specified by the State along with an invoice that will be sent to each MCO, by 1:00 p.m. Central Time, on the preceding Friday of each week:
 - (a) All transactions (i.e., claims, financial adjustment, etc.) identified by Managed Care Organization (MCO) that were submitted through its TennCare POS system for that work week.
 - (b) All payments, (check register) identified by MCO, to be made on Friday of that week. The State shall be notified no later than one (1) business day of any systems or operational issues that may impact disbursements by the prescribed deadline. The file described in Contract Section A.42.b.2(a) above shall contain all transactions that make up the payments in the file described.

3. The State shall pay each MCO directly for their pharmacy spend.(total of ten invoices). In turn, each MCO will pay these funds to the Contractor. The weekly payment schedule works as follows:

Friday	Invoices and Files Submitted by Contractor to TennCare by 1:00 p.m.
Monday	TennCare Accounting keys payment of Pharmacy Invoices to MCO's by 10 am
Wednesday	MCO's receive funds from TennCare
Thursday	MCO wires payment to Contractor
Friday	Pharmacy Provider Checks are mailed by 2:00 pm

4. The Contractor shall ensure that collection letters are sent to contracting pharmacies that maintain an accounts-payable balance to the State greater than ninety (90) days. These notices shall be sent within five (5) business days of becoming ninety (90) days old. The Contractor shall provide the State with a monthly report of notices sent, due within ten (10) business days after end of month of reporting period. Postage costs incurred by the Contractor for this purpose shall be treated as pass-through costs. In addition to regular invoices, these costs shall be billed on a monthly basis to the State and shall include any necessary substantiating documentation. Printing and supply costs for collection mailings shall be included in the Contractor's administrative fee. Any amounts ultimately deemed uncollectible shall be submitted to the TennCare Accounting Office to be considered for write-off per State write-off procedures.
5. The Contractor shall provide the TennCare Accounting Office a report detailing all checks remitted to contracted pharmacies on behalf of the State that remain outstanding more than ninety (90) days. Reports are due monthly on the fifteenth (15th) day of the month following the reporting period. The Contractor shall initiate additional follow up on outstanding provider checks as requested by the TennCare Accounting Office.
6. The Contractor shall mail checks and remittance advices for claims that were submitted through its TennCare POS system for that work week on Friday of the following week., -. The TennCare Accounting Office will work to coordinate schedule changes for payments in the event of holidays or other office closure. In the event that the Contractor has not received funding for provider payments by Friday due to other mitigating circumstances, the Contractor must receive approval from the TennCare Accounting Office to delay the mailing of provider checks until funding arrives.
7. The State reserves the right to review the files prior to issuing payment and to hold or adjust payment that is in error or missing information. The Contractor is required to offer electronic funds transfer to providers. If the Contractor submits a claims payment request and the State overpays the claim, the State reserves the right to withhold the overpaid monies from future payments. The Contractor shall be responsible for providing remittance advices to providers unless the provider elects not to receive a remittance advice. Remittance Advices shall be included in payments by the Contractor to providers. The Contractor shall comply with the American Standards Committee Health Care Claim Payment/Advice known as the "ASC 835". The ASC 835 is a HIPAA compliant format. The Contractor shall be responsible for ensuring that any provider payments are accurate and compliant with the terms of this Contract. In addition the payments must be made in accordance with the provider agreement as well as all applicable state and federal laws and regulations.
8. The Contractor shall have in place a POS claims processing system capable of accepting and processing claims submitted electronically. To the extent that the Contractor compensates providers on a fee for service or other basis requiring the submission of claims as a condition to payment, the Contractor shall electronically process the provider's claims for covered benefits provided to members consistent with applicable TennCare policies and procedures and the terms of this Contract.

9. The Contractor shall, if appropriate, pay within fifteen (15) days of receipt one hundred percent (100%) of all clean claims submitted by network and non-network pharmacy providers through POS and batch electronic claims submission. The term "pay" means that the Contractor shall either send the provider cash or cash equivalent in full satisfaction of the clean claim, or give the provider a credit against any outstanding balance owed by that provider to the Contractor. The Contractor shall pay the clean claim or advise the provider that a submitted claim is: (1) a "denied claim" (specifying all reasons for denial); or, (2) an "incomplete claim" that cannot be denied or allowed due to insufficient information and/or documentation (specifying in detail all information and/or documentation that is needed from the provider in order to allow or deny the claim). An incomplete claim may be resubmitted with the information necessary to complete the claim. This resubmission shall constitute a new claim only for the purpose of establishing a timeframe for claims processing.
10. The Contractor shall be responsible for processing all TennCare pharmacy claims through a POS system using the specified, current NCPDP format. Pharmacy claims shall be priced and adjudicated in an online, real time POS system that results in a claim pay status of pay, deny or reject. The system must allow a pharmacy to initiate a reversal (void) of a submitted claim. The telecommunications system supporting the POS function shall be available for claims submissions by pharmacies twenty-four (24) hours-a-day, seven (7) days-a-week (except for regularly scheduled and separately approved downtimes). The Contractor shall not charge pharmacies a POS transaction fee. TennCare PBM providers are responsible for purchasing POS hardware, software and all telecommunications linkages. The POS function shall be required of all pharmacy providers. The Tennessee Department of Health may submit batch claims as described herein.

A.42.c. TennCare Claims Receipt and Management

1. The Contractor shall receive batch electronic and point of sale (POS) claims. The Contractor shall apply a unique identification number to each claim and any supporting documentation regardless of submission format. The identification number shall be used to recognize the claim for research or audit purposes. Control totals shall be utilized to ensure that all claims have been processed to completion. Appropriate safeguards shall be in place to protect the confidentiality of TennCare and enrollee information.
2. At the point of sale, the Contractor shall identify and deny claims that contain invalid provider numbers. This shall include cases where the number is missing, the check digit fails, or the provider number does not identify an entity to receive a Remittance Advice. Claims that contain these errors shall be returned to the originating provider. Pharmacy providers shall submit claims and be identified by their individual and specific NPI (National Provider Identification) numbers. Prescribers shall be identified on all pharmacy claims by their specific NPI. The Contractor shall comply with TennCare approved policy and procedures for sending enrollees whose claims were denied a Notice of Adverse Benefit Determination and sending a denial letter to the Provider.
3. The Contractor shall identify and deny claims (unless specifically instructed differently by the State) that contain National Drug Code (NDC) numbers for which drug rebates under the Omnibus Budget Reconciliation Act (OBRA) of 1990 and subsequent amendments of OBRA in 1993, are not available, including non-covered drug codes, DESI, LTE and IRS drug codes and any terminated or obsolete drug codes. Such claims shall reject with situation specific messaging and error codes.
4. Unless a claim resolution is being managed by TennCare staff in accordance with TennCare guidelines or held by the Contractor under TennCare written directive, the Contractor shall be held to the following timeline requirements:

- (a) POS Claims - The Contractor shall process ninety-nine and a half percent (99.5%) of POS claims on a daily basis within ten (10) seconds of receipt by the Contractor's processor. This is the time from when the claim is received by the Contractor's processor to the time the results are transmitted from the Contractor's processor and shall include all procedures required to complete claim adjudication. The Contractor shall notify TennCare within one hour (1) of sub-standard system performance.
 - (b) Batch Electronic Claims - The Contractor shall receive claims in electronic format, via batch transmission. All batch claims shall be scheduled for immediate processing. The Contractor shall assign identification control numbers to all batch claims within three (3) business days of receipt. The Contractor shall maintain electronic backup of batch claims for the duration of this Contract. At the end of the Contract, the Contractor shall follow the guidelines set forth in the Business Associate's Agreement with the State. If the State requests copies of batch electronic claims, these shall be provided within three (3) business days of request. Electronic batch claims shall be submitted through a method that shall allow batch and POS claims to be adjudicated through the same processing logic.
5. The Contractor's system shall operate without unscheduled or unapproved downtime. The Contractor shall report to TennCare immediately (within one (1) hour) upon knowledge of unscheduled or unapproved downtime. A system down or "downtime" shall be defined as an interruption involving more than ten percent (10%) of production for a period greater than fifteen (15) minutes. The Contractor shall also provide the State with updates at regular intervals during a sustained downtime lasting longer than two (2) hours. The State shall be presented with recovery options as appropriate. Upon full system recovery, the Contractor shall provide The State with a System Downtime Analysis describing root cause issues and actions to mitigate future downtime occurrences within five (5) business days after full system recovery.
6. TennCare Help Desk for System Support - The Contractor shall maintain toll-free telephone access to support system operations. The Help Desk shall be staffed by clinical pharmacist(s) who shall be physically on duty (not on call) twenty-four (24) hours a day, seven (7) days a week to respond to questions and problems from providers regarding system operations and claims inquiries. The Contractor shall supply all the required information systems, telecommunications, and personnel to perform these operations. In no event shall the Contractor use off shore sites for any area of performance of this Contract.

A.42.d. TennCare Data Validation Edits and Audits

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

The Contractor shall notify the State in writing of any and all claims that have been erroneously processed in accordance with Contract Section A.33. The Contractor shall initiate appropriate action to correct the errors, such as but not limited to adjustments and recoveries within twenty-four (24) hours of discovery. Incorrect claims include, but are not limited to: claims paid for ineligible members; claims paid to a terminated Provider and/or a Provider not holding a valid Tennessee Medicaid provider number and/or a Provider who was not eligible to provide TennCare services for the entire claim dates of service; claims paid for duplicate services; claims paid for a non-covered service; and claims paid at an incorrect rate or claims that denied or rejected inappropriately. In addition to the requirements of Contract Section A.33, the Contractor shall follow-up such notification to the State by letter and provide

a report documenting all claims paid resulting from any system errors that resulted in provider overpayment or other incorrect payment. The Contractor shall reimburse the State for the cost of all claims paid as a result of Contractor error. Reimbursement or damages resulting from this Section may be applied as offsets to future administrative fees.

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

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

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

1. TennCare Prior Authorization - The system shall determine whether a prescribed drug requires prior authorization, and if so, whether approval was granted prior to dispensing the prescribed drug and reimbursement to the provider.
2. TennCare Supplemental Messaging - The Contractor's TennCare POS system shall be capable of customizing supplemental messages in lieu of standard denial codes, to contain alternative therapies listed on the TennCare PDL.
3. TennCare Valid Dates of Service - The system shall ensure that dates of services are valid dates, are no older than one hundred eighty (180) days from the date of the prescription (unless approved by the State) and are dates that have already occurred (not dates in the future).
4. TennCare Duplicate Claims - The system shall automatically inform the provider that the current claim is an exact or possible duplicate and deny that claim as appropriate.
5. TennCare Prescription Validity - The system shall ensure that the time period for a prescription has not expired and that the number of valid refills has not been exceeded.
6. TennCare OTC Drugs - TennCare covers medically necessary OTC drugs for children (under twenty-one (21) years old) and a selective list (e.g., prenatal vitamins for women up to age 50) for adults. OTC drugs shall only be covered to the extent that they are prescribed by a health care provider legally qualified to write prescriptions. The Contractor shall have appropriate processes in place to assure that OTC drugs are only reimbursed as described above, or in another manner as described by the State.
7. TennCare 340B Claims - The TennCare POS system shall capture, edit and adjudicate pharmacy claims as necessary to support TennCare's 340B claim rules, as well as support a customized pharmacy Network of 340B providers. System shall ensure that claims transmitted by pharmacies that are flagged as 340B claims, are rejected if not received from pharmacies that are contracted as 340B providers.
8. TennCare Compounded Drugs - The system shall capture, edit, and adjudicate pharmacy claims as necessary to support TennCare compounded drug prescription coding policy and/or rules. All system edits that are in place for non-compounded prescriptions shall be in place and active for compounded prescriptions (e.g. prior authorization).

9. TennCare Provider Validation - The system shall approve payment only for claims received from Providers who are eligible to provide pharmacy services and hold a Tennessee Medicaid provider number, and for TennCare and non-TennCare providers who are authorized and/or registered or eligible as a TennCare Provider for the entire claims dates of service (as required by the State) to prescribe pharmaceuticals. The system shall be populated with current, updated pharmacy and prescriber provider location and contact information.

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

10. TennCare Recipient Validation – A Valid Claim is a claim for service for those members eligible to receive pharmacy services at the time the services were rendered. The system shall approve only Valid Claims. The State shall transmit eligibility/enrollment information to the Contractor Monday through Friday, excluding State holidays, by the standard HIPAA compliant 834 Transaction as defined by the ASC X12N 834 TR3 and TennCare Companion Guide. The State shall be responsible for assuring that the eligibility file provided is accurate and complete. The Contractor shall use this information to immediately (within one (1) business day) identify individuals added, or whose enrollment status has changed, update the eligibility information in the Contractor's data system, and take appropriate action as outlined below. The NCPDP Post Adjudication Standard 4.5 format shall be used for encounter reporting sent to the State. If the Contractor has been billed for any claims for a recipient who was deceased at the time the service was allegedly provided or who is no longer eligible for TennCare, then the Contractor shall be required to recoup monies paid to any provider that had knowledge of, or should have had knowledge of the recipient's death and to repay any monies collected by the Contractor for the claims that were paid post date of death or post eligibility for enrollment. On a monthly basis, the Contractor shall report the amount recouped by the Contractor and the amount to be repaid to the State. In addition, the Contractor shall reimburse the State monthly for monies owed to the State as a result of billing for recipients not eligible to receive services.
11. TennCare Quantity of Service - The system shall validate claims to ensure that the quantity of services is consistent with TennCare policy and/or rules (i.e., verify that drug specific minimum and maximum quantity limitations, as well as days' supply and number of prescriptions per month limitations, if imposed, are followed as directed by the State). The system shall have the capability to accumulate total quantities and/or equivalent dosing across different drugs within therapeutic categories (i.e. calculation of Morphine Equivalent Daily Dose).
12. TennCare Rejected Claims - The system shall determine whether a claim is acceptable for adjudication and reject claims that are not. Contractor shall follow all TennCare approved policies and procedures regarding rejected claims and requirements to send Notice of Adverse Benefit Determination to TennCare enrollees and claim denial communication to submitting Providers.
13. TennCare Third Party Liability/Coordination of Benefits. The Contractor shall be responsible to ensure that TennCare is the payor of last resort in all situations where an enrollee has other health insurance coverage (Other Insurance), and to ensure that all COB (Coordination of Benefits) claims are being adjudicated only when Other Insurance has been exhausted first. The Contractor shall obtain current information regarding enrollees' Other Insurance in addition to TennCare, and perform daily updates to a third party liability (TPL) file. The TPL file shall then be used to enable

the point of service (POS) system to validate claims to determine whether there is a liable third party.

In situations where Other Insurance coverage is detected for the date of service, an edit shall be generated at the POS prompting the pharmacy to transmit the claim to the Other Insurance prior to transmitting the claim to the TennCare pharmacy benefit. The following information shall be included in the POS messaging, when available: Phone number for the primary Other Insurance, Bank Identification Number (BIN), Processor Control Number (PCN), Group Number, and Cardholder ID. The POS system shall be able to adjudicate claims where there may be more than one (1) liable Other Insurance. In the event that the amount paid by the Other Insurance(s) exceeds TennCare's maximum allowable, then the claim shall return a paid amount of zero (\$0.00) through TennCare.

In addition, the system shall allow pharmacies to override the TPL edit at the POS level with the use of National Council for Prescription Drug Programs (NCPDP) standard Other Coverage Code (OCC) overrides. The Contractor shall provide pharmacy assistance with TPL edits/coordination of benefits (including use of OCC overrides) through the Technical Pharmacy Help Desk (described in Section A.47 of this Contract).

- A. TennCare reserves the right to require the Contractor to use a TPL file provided by the State. Should TennCare require Contractor to use the State's TPL file, TennCare will be responsible for providing an updated TPL file to the Contractor on a regular basis, which will include all known beneficiaries with active Medicaid eligibility and active prescription benefit coverage with another payor, including both commercial coverage and Medicare Part D coverage. The layout of the file shall include the following key elements at a minimum to ensure the Contractor has the necessary data to coordinate Other Insurance at the POS:
- a. Recipient Medicaid ID
 - b. Recipient Last Name
 - c. Recipient First Name
 - d. TennCare Carrier Code
 - e. Carrier Name
 - f. Carrier Address
 - g. Carrier Group Number
 - h. Policy ID
 - i. Effective Date
 - j. End Date
 - k. Coverage Code

TennCare will work with the Contractor on a method to transfer this file and confirm receipt.

- B. Should TennCare not require the Contractor to use the State-provided TPL file, Contractor shall provide the TPL file utilized by the Contractor to TennCare on a monthly basis in a format approved by the State. The layout of the file shall include at a minimum, the key elements in Contract Section A.42.d.13.A above. TennCare will work with the Contractor on a method to transfer this file and confirm receipt.
- C. TPL Audit. To ensure that the Contractor correctly uses either the State-provided TPL file, or Contractor's file, TennCare shall request a third party vendor to conduct a monthly TPL audit of paid claims and claims denied solely with NCPDP Denial Codes "41" and "13". Audit will be performed by the third party vendor using the State-provided TPL file and Contractor's TPL file to ensure that all Other Insurance is exhausted before TennCare makes any payment on any claim. The Contractor shall provide the files as required by the third party vendor. All disputes between the Contractor and the third party vendor shall be resolved by the State at the State's sole discretion.

- D. Pharmacy Provider Analysis. Contractor shall educate pharmacy providers regarding proper billing practices and carrier codes associated with NCPDP's current version. The Contractor and the Contractor's POS system shall strictly adhere to state and federal laws and regulations and TennCare policy and/or rules regarding coordination of benefits and third party liability.
 - a. Contractor shall use reporting and other means of analyses to determine whether network pharmacy providers are making all efforts to use the information received in POS messaging with the denial to transmit the claim to the primary payor prior to transmitting to TennCare.
 - b. Pharmacy providers that are found as outliers with high percentages of denied claims without a final claim paid by either the primary payor or by TennCare shall be audited, and corrective action shall be taken if claims could have been paid by the primary payor or TennCare.
 - c. Pharmacy providers that are found as outliers with high percentages of claims paid by TennCare with OCC codes "0" (member does not have Other Insurance) and "1" (pharmacy cannot determine the valid Other Insurance identity) shall be audited, and corrective action shall be taken if claims could have been paid by the primary payor.
 - d. Contractor shall ensure that pharmacy providers are not denying benefits to TennCare enrollees in order to avoid using the TPL/COB process.
- 14. TennCare TPL Fees. TennCare shall not pay Contractor any additional TPL Fees or TPL per claim fees for TPL services described in this Section of the Contract. Contractor shall be compensated for all TPL services as part of their monthly Administration Fee.
- A. TennCare Monthly TPL Reports. The Contractor shall provide the State with the following TPL reports for the preceding month by the fifteenth (15th) day of each month:
 - a. TennCare Monthly TPL Claims Detail- The Contractor shall provide a Monthly TPL Claims Detail report that identifies:
 - i. each instance in which a claim has been denied because TPL was identified by the POS system but the prescription was not filled using the TPL information,
 - ii. all claims that were paid using TPL information provided to a pharmacy by the POS system,

TennCare will work with the Contractor and third party TPL audit vendor on a claims file layout and on a method to transfer this file and confirm receipt.

- 15. TennCare Lock-in - The system shall have the capability to impose a Lock-In, as defined in Attachment A, such as pharmacy and prescriber benefit restrictions that apply to a given recipient and any specific Lock-In conditions. Information inputted into the system for purposes of Lock-In programs must be readily retrievable from the system for reporting purposes.
- 16. TennCare Managed Care Organizations - Contractor shall identify products that should be administered as a medical benefit. The system shall reject claims that are required to be processed and paid by a member's MCO for any and all medical benefits (when that MCO is responsible for those claims). Contractor shall assist The State in identifying new and existing products that should not be considered as pharmacy claims based on Contractor's experience with other State's programs. Once identified, a list of drugs shall be created, published and updated quarterly by the contractor.
- 17. TennCare Early Refills - The systems shall be able to recognize when an enrollee attempts to refill a prescription (either the original prescription or a new prescription

for the same drug) and require that ninety-five percent (95%) of controlled products and eighty-five percent (85%) for non-controlled products or any other percentage threshold as directed by The State, of the original days' supply has passed since the original filling. Overrides at the pharmacy level shall be permitted by the Contractor's Help Desk for drug categories as directed by The State, but monthly reports shall identify the enrollee and the pharmacy provider where such overrides occurred.

18. Tiered Co-pay Edit - A tiered co-pay structure shall be coded into the POS system. Initially, only two (2) tiers may be established. At a later date, a more complex structure may be required by the State without any additional cost to the State. Contractor's system shall accommodate tiered co-pay structures based as defined by the State including but not limited to brand versus generic or preferred versus non-preferred products. System shall accommodate preferred versus non-preferred products tiered co-pays with or without regard to whether the drug is a brand or generic product.
19. TennCare Usual and Customary (U&C) – Reimbursement logic shall compare the sum of the ingredient cost and dispensing fee to the submitted U&C amount and pay the lesser amount.
20. TennCare Maximum Dollar Amount Edit – All pharmacy claims over a specified dollar amount per claim shall reject at the POS and the pharmacy provider shall be required to call the Contractor Call Center regarding rejected claims. This includes a two hundred fifty dollar (\$250) limit on compounded claims (including intravenous compounds), a one thousand five hundred dollar (\$1,500) limit on non-compounded, non-exception claims, and a forty thousand dollar (\$40,000) limit on exception claims (blood factors and other identified products). The Contractor's system shall be capable of adding, changing, or removing maximum dollar edit rules at no cost to the State when requested by the State. Contractor shall monitor claims that trigger the Maximum Dollar Amount Edit on a quarterly basis and make recommendations on adjustments of clinical criteria and/or quantity limits to coincide with Pharmacy Advisory Committee and Drug Utilization Review board meeting preparation. Recommendations shall be carried forward as determined by the State.
21. TennCare Prescriber Number Edit - The POS claims processing system shall be configured to require that all claims shall be submitted with the prescriber's NPI number. The validity of NPI numbers shall be determined by the most current data available from the CMS Plan and Provider Enumeration System (NPPES).
22. TennCare Unit of Measure Edit - The Unit of Measure (UOM) edit shall perform two (2) main functions:
 - (a) Check incoming claim units (i.e., gram, milliliter, etc.) versus the units listed in Reporting System for that particular NDC; and
 - (b) Verify that the unit amounts transmitted is consistent with the unit amounts in Reporting System. The submitted quantity shall be a multiple of the unit size shown in Reporting System (i.e., claim shall be rejected if unit amount transmitted has been rounded). For example, the units transmitted is fourteen (14), but the unit amount is thirteen point seven (13.7) in the Reporting System.
23. TennCare Prescriber Last Name Edit -The claims processing system shall be set to ensure that the submitting prescriber's last name correctly matches the last name associated with the NPI number.

Throughout the term of this Contract, the Contractor shall be responsible for making recommendations to the State regarding the need for the edits, associated criteria and call center protocol development. The Contractor and TennCare staff shall agree

upon criteria to produce a retrospective report containing findings and recommendations for prevention of such practices.

A.42.e. TennCare Prospective Drug Utilization Review (Pro-DUR)

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

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

The Contractor's POS system shall be capable of applying results of Pro-DUR processing in the claim adjudication process. Claims that reject as a result of Pro-DUR processing shall include situation specific messaging and error codes that enable the pharmacy provider to take appropriate actions. The Contractor may use an existing Pro-DUR package but shall make any modifications required by TennCare at no cost to the State. The Contractor shall work with TennCare in setting the disposition of Pro-DUR edits that may vary by type of submission (e.g., POS versus batch). The Contractor's system shall include the following minimum prospective drug utilization review (Pro-DUR) features at installation:

1. TennCare Potential Drug Problems Identification - The Contractor's system shall accept and use only TennCare-approved criteria and shall perform automated Pro-DUR functions that include, but are not limited to:
 - (a) Automatically identify and report problems that involve potential drug over-utilization;
 - (b) Automatically identify and report problems that involve therapeutic duplication of drugs when the submitted claim is associated with other drugs or historical claims identified for a given enrollee;
 - (c) Automatically identify and report problems that involve drug use contraindicated by age, gender and presumed diagnosis codes on historical claims for a given enrollee, or if requested by TennCare, based on actual diagnosis information provided by TennCare in a format mutually agreed upon by Contractor and TennCare;
 - (d) Automatically identify and report problems that involve drug use contraindicated by other drugs on current or historical claims for a given enrollee (drug-to-drug interactions);
 - (e) Automatically indicate and report the level of severity of drug/drug interactions;
 - (f) Automatically identify and report potentially incorrect drug dosages or limit the quantity per prescription to ensure the most cost-effective strength is dispensed.
 - (g) Automatically identify and report potentially incorrect drug treatments;
 - (h) Automatically indicate and report potential drug abuse and/or misuse based on a given members prior use of the same or related drugs; and

- (i) Automatically identify early refill conditions and provide, at the drug code level, the ability to deny these claims;
2. TennCare POS Provider Cancel or Override Response to Pro-DUR Messages – Prior to the final submission of POS pharmacy claims, the Contractor's system shall automatically generate Pro-DUR messages in a manner that shall enable a pharmacy provider to cancel submission of the claim or to submit it if it is a message that can be overridden.
3. TennCare POS Provider Comment on Pro-DUR Messages - The Contractor's system shall allow providers to enter responses utilizing NCPDP Professional Pharmacy Services (PPS) intervention codes in response to Pro-DUR messages. The system shall capture and store all NCPDP standard DUR conflict, intervention, and outcome messages for reporting to TennCare. The Contractor shall make changes to the PPS intervention configuration as directed by TennCare at no cost to the State.
4. TennCare Flexible Parameters for Generation of Pro-DUR Messages - The Contractor's system shall have the ability to transmit new or revised Pro-DUR messages and to define the Pro-DUR criteria that activate these messages. The system shall maintain a State-controlled set of parameters applicable to the situations involving generation of online Pro-DUR messages. The system shall provide and permit the use of all general system parameters regarding data access, support, and maintenance. Variables subject to the State's definition and control include, but are not limited to: NDC code (including multiple NDC codes subject to potential drug/drug interaction); date of service; drug strength; drug quantity; daily supply; and Generic Product ID (GPI), Generic Drug Code (GCN) or Generic Sequence Number (GSN).
5. TennCare Pro-DUR Enrollee Profile Records - The Contractor's system shall provide and maintain enrollee profiles for Pro-DUR processing of submitted claims. Recipient profiles shall be based on inferred diagnoses from pharmacy claims, actual diagnoses from medical claims provided by the State to Contractor, and other available data.
6. TennCare Disease/Drug Therapy Issues Screening - The Pro-DUR system shall have the capability to screen for drug therapy concerns by specific drugs relative to high-risk disease, to include but not limited to: cardiovascular disease; cerebrovascular disease; central nervous system disease; renal disease; endocrine disease; gastrointestinal disease; psychiatric disease; and respiratory disease.
7. TennCare Patient Counseling Support - The Contractor's system shall present Pro-DUR results to pharmacy providers in a format that supports their ability to advise and counsel members appropriately.

A.42.f. TennCare Prescription Limits

1. The Contractor's system shall have the capability to adjudicate different benefit packages for enrollees based on the enrollee's benefit code as transmitted on the 834 Eligibility File. The system shall have the capability to be edited to limit the number of claims per month for enrollees with specific benefit codes. A "soft" limit restricts dispensing to the specified limit with the exception of drugs included on one of two lists (Auto Exemption and Prescriber Attestation) developed by the State. As of the beginning date of this Contract, the prescription limit applies to most adults, is calculated on a monthly basis and is set at five (5) prescriptions per month of which no more than two (2) may be brands.
2. TennCare Prescription Limit Overrides - The Contractor shall support two (2) mechanisms for allowing the coverage for prescriptions beyond the programmed

edits. The first, known as the Auto-Exemption List, shall be developed by the State with the assistance of the Contractor and shall include products that shall never count against the prescription limit. The second, known as the Prescriber Attestation List, shall normally count against the prescription limit unless the prescriber obtains the necessary approval. The Contractor shall be responsible for developing the process to support both long and short term override capabilities.

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

3. **TennCare Emergency Supply Override** -The Contractor shall assure that the TennCare-POS systems allows pharmacists to execute an emergency override that shall process an emergency seventy-two (72) hour supply of drugs in normally covered therapeutic categories that are non-preferred or would otherwise require prior authorization. The Contractor's TennCare-POS system shall be capable of customizing supplemental messages in lieu of standard denial codes, to contain alternative therapies listed on the TennCare PDL. Drugs eligible for the emergency override shall be in a therapeutic class normally covered by TennCare. The Contractor's system shall allow for differentiation of drug categories that can be overridden by the pharmacist in the POS system and drug categories that the pharmacy shall call the technical call center for an override. The Contractor shall instruct pharmacy providers how to transmit the emergency override claims submission to Contractor's claims processing system.
4. Contractor shall be responsible for oversight and enforcement of the pharmacy provider network, and shall ensure that network providers offer a seventy-two (72) hour emergency supply when appropriate. Contractor shall take appropriate corrective actions for pharmacies who fail to comply with the seventy-two (72) hour emergency supply rule. Contractor shall track seventy-two (72) hour emergency supply prescriptions by pharmacy, along with the number of claims that are transmitted by the same pharmacy resulting in denials due to prior authorization being required. Contractor shall take action by providing education to pharmacies that have not transmitted seventy-two (72) hour emergency supply prescriptions and shall require corrective action from those providers who continue to not submit seventy-two (72) hour emergency supply claims. Continued lack of seventy-two (72) hour emergency supply claims from Providers may be considered a breach of their Provider Agreement. Contractor shall report on a weekly basis in a format to be specified by the State, information regarding all new, changed or inactivated Pharmacy Providers.
5. **TennCare Emergency Supply Copays** – The enrollee shall not be charged a copay for the emergency supply. The emergency supply shall count against the monthly prescription limit. However, if later in the same month the provider obtains a Prior Authorization (PA) or changes to a drug not requiring a PA, the remainder of the prescription and /or the substitute prescription shall not count against the monthly prescription limit.
6. **Number of Emergency Supplies per TennCare Enrollee** - Only one (1) seventy-two (72) hour supply shall be provided per patient, per prescription. Prescription refers to the entire course of therapy ordered by single prescription (i.e., first fill and subsequent refills included with the order for the first fill). In addition, only one (1) seventy-two (72) hour supply shall be provided per patient, per GSN, GPI, or industry equivalent, per month.

A.42.g TennCare Pharmacy Claim Processing and Payments

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

1. All payments for pharmacy claims shall be made through the Contractor's system and electronically invoiced to the State weekly.
2. Claims pricing is driven by the pricing methodologies set by TennCare rules and policies. Contractor's system shall have the ability to support any pricing methodology adopted and outlined in TennCare's State Plan Amendment and is based on any of Estimated Actual Cost (EAC) formulae, Actual Acquisition Cost, Average Acquisition Cost, or based on the use of CMS' published NADAC and FUL drug pricing files. Contractor's system shall have the ability to support separate pricing methodologies for various pharmaceutical distribution and provider types (e.g. specialty pharmacy, LTC pharmacy, 340b pharmacies) if requested by the State. The system shall compare the calculated allowed (i.e., quantity multiplied by price plus the dispensing fee) to the pharmacy's submitted Usual and Customary retail price and authorize payment based on the lower of the two. The Contractor's system shall allow for such any price adjustments submitted by the TennCare Pharmacy Director or his/her appropriate staff to be effective within two (2) business days. The Contractor's system shall allow the use of NCPDP standard Dispense as Written (DAW) codes, which shall be defined by the State.
3. The Contractor's system shall have the capability to adjudicate different copays for groups of enrollees based on the enrollee's copay code. The system shall recognize all applicable copays or coinsurance and deduct that amount from the payment made to the pharmacy provider. The Contractor shall be required to report copay, coinsurance and deductible information to the State as required by the State and the TennCare MMIS Manager.
4. For the purposes of this Contract, an adjudicated claim shall not include a point-of-sale transaction that was canceled by the sender or a claim that was rejected before it could be fully adjudicated.
5. The Contractor shall be responsible for the preparation of any applicable tax information for service provider payments and the federal government (i.e., Form 1099).
6. The Contractor shall be able to support any/all changes to discount rates and standard pharmaceutical pricing methodologies (i.e. AWP, AAC, WAC, CMS NADAQ, CMS FUL) and incorporate them into pharmacy claim pricing policies at the sole discretion of the State at no additional cost.
7. TennCare Professional Dispensing Fee (PDF).
 - (a) The State may periodically require the Contractor to have all Contractor Providers in its TennCare PBM Program network provide, as requested by the Contractor, the State, and the TennCare PDF and AAC contractors (if applicable) all requested TennCare PDF and AAC information, including but not limited to, complete and timely responses to any TennCare PDF and AAC questionnaire that is sent to all Contractor Providers providing PBM services to TennCare enrollees. Failure by such Contractor Providers to cooperate or to timely assist in the collection of information necessary to establish TennCare PDF and AAC rates, may result in exclusion from the Contractor's TennCare PBM Program provider as set forth in the Contractor Provider Service Agreement/Addendum.
 - (b) Coordination and Collaboration Responsibilities of Contractor and its Providers serving TennCare PBM Program enrollees. The Contractor and its Providers shall, as directed by the State or other State contractors, and at no

additional cost to the State, coordinate with, facilitate the prompt exchange of information between, and work collaboratively with any and all other State contractors and Federal and/or State Agencies for the purposes of periodically updating TennCare PDF and AAC rates as required by CMS.

A.42.h. TennCare Reversals and Adjustments

The system shall provide an efficient means of reversing or adjusting claims before and after the claim has been transmitted to the MMIS. If reversed or adjusted, this additional claim information shall be transferred to MMIS for further processing. The State shall not pay the Contractor for reversed, voided or adjusted claims that result in zero payment to the Provider. The Contractor shall process all reversals requested by the State's fiscal unit within thirty (30) days and provide confirmation to the State's fiscal unit upon occurrence.

A.42.i. TennCare Manual Claims

1. TennCare's appeals unit may submit to the Contractor's manual claims unit, paper claims for those members who were eligible to receive pharmacy services at the time services were rendered. Manual claims may contain multiple products and/or services. Each manual claim shall include sufficient information to allow the Contractor to identify the member and the covered product and/or service, which information shall include, but not be limited: (1) the complete member name, including middle initial (if applicable); (2) the amount paid; (3) the name of the pharmacy that dispensed the prescription; (4) prescription fill date separate and distinguishable from the manual claim adjudication date; (5) name of product; (6) amount of prescription dispensed; and (7) the number of days prescription was written for. In the event that the claim information does not include the data elements necessary for the Contractor to adjudicate a transaction using the TennCare POS system, the Contractor shall directly contact the applicable pharmacy, member and/or doctor in order to obtain sufficient documentation containing the missing information. Once the Contractor has received the necessary data elements, the Contractor shall enter the applicable data elements for each transaction into the TennCare POS system for adjudication. If the Contractor does not receive the necessary data elements then they shall notify TennCare appeals unit within ten (10) calendar days from original receipt from TennCare appeals unit.
2. If the transaction is adjudicated by the TennCare POS system and such adjudication results in a "paid" status, the Contractor shall submit payment directly to the applicable member for the applicable transaction using the address information contained in the TennCare POS system.
3. If the transaction is adjudicated by the TennCare POS system and such adjudication results in a "rejected" status, the Contractor shall inform the TennCare appeals unit.
4. The Contractor shall mail notice to member for all manual claims that could not be reimbursed.
5. The Contractor shall complete the process set forth in Section A.42.i above within fourteen (14) calendar days or as otherwise specified in Contract Section A.42.i.
6. Notice to enrollee shall reference the pharmacy date of service.

A.43. TennCare Preferred Drug List (PDL)

The Contractor shall manage the PDL program in an ongoing manner, which assures that new drugs and clinical information are addressed appropriately. PDL changes will be reviewed by the TennCare Pharmacy Advisory Committee and coordinated with the Contractor's supplemental rebate offers. The Contractor shall ensure that the PDL decision-making process is evidence-based, assures enrollee access to clinically superior drugs, and

takes into account the relative cost of therapeutically equivalent drugs. The Contractor shall identify for the State therapeutic alternatives and opportunities for savings, including opportunities to promote competition to drive rebate bidding. The Contractor shall also make recommendations concerning therapeutic categories that should be avoided with regard to inclusion on the TennCare PDL.

The Contractor shall advise and update the State on all drugs in development, and all potential changes in the pharmacy marketplace potentially affecting TennCare's drug spend, including but not limited to, monthly brand as generic savings, PDL market shifts, and weekly drug file additions. The Contractor shall present to the State on a quarterly basis new market entries expected within the next sixty (60) to one hundred eighty (180) days, and new brand-to-generic market changes, along with recommendations on how to best manage these new entries and changes. The Contractor shall also design and implement a process that ensures that State approved changes will become effective within ten (10) business days of the occurrence.

A.43.a. TennCare Preferred Drug List (PDL)

1. The Contractor shall design, develop, implement, administer and maintain a TennCare PDL program. On the date the Contractor assumes full responsibility for the TennCare PBM Program, the Contractor shall assume responsibility for administering and maintaining the existing PDL, including the existing prior authorization criteria. A limited number of preferred drugs may be prescribed and dispensed with no prior authorization. Non-preferred drugs may be prescribed, but require prior authorization from the Contractor prior to being dispensed by the pharmacist and reimbursed. As the PDL is re-evaluated and/or expanded, the Contractor shall develop, propose, and publish interim prior authorization criteria for non-preferred drugs and certain preferred drugs and present those criteria first to the State for acceptance/approval, and then to the TennCare Pharmacy Advisory Committee for review and input and to the State for final approval. Final decisions for inclusion or exclusion from the TennCare PDL shall be at the sole discretion of the State.

The Contractor shall prepare and maintain a document suitable for printing or posting to the TennCare website providing the PDL listing and all applicable interim and standing drug prior authorization (PA) criteria including step-therapy algorithms. Prior authorization criteria and procedures shall be fully disclosed to the State.

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

2. The TennCare PDL shall be designed to maximize the prescribing and dispensing of safe and clinically effective drugs within each therapeutic class that are the most cost-effective. Conversely, the TennCare PDL shall ensure that more costly drugs, which do not have any significant clinical or therapeutic advantage over others in their class, are used only when medically necessary.
3. The Contractor's PDL design shall include a stringent clinical review of clinical guidelines and medical literature to identify which agents and classes of drugs shall be subject to the PDL program. Within the classes of drugs determined to be subject to the PDL, the Contractor shall determine which drugs within each class are safe, clinically effective, and provide equivalent clinical outcomes. Recommendations for inclusion on the PDL to the State shall be based on a thorough review of clinical effectiveness, safety, and health outcomes, followed by an analysis of the relative

costs of the drugs in each class under consideration, with the State approving the final recommendations to be presented to the TennCare PAC.

4. Drugs within a reviewed class that are excluded from the PDL shall be considered non-preferred and require prior authorization by the Contractor's Prior authorization unit in order to be dispensed to a TennCare member.
5. The Contractor shall establish policies and procedures describing the manner in which pharmaceutical manufacturer industry personnel contact appropriate Contractor staff. This should include specifying which Contractor staff may be contacted and the content of discussions when contact or visits take place. Further, the policies shall restrict contacts and visits to discussions related to the TennCare PDL and to appropriate pharmaceutical manufacturer personnel. The Contractor's policies shall guide the content of discussion and forum for such discussions with pharmaceutical manufacturers as they relate to the TennCare PDL. Contractor's clinical pharmacists at the State's offices in Nashville, Tennessee shall facilitate, schedule and meet with pharmaceutical manufacturer's representatives. The Contractor's policies shall be approved by the State. Nothing in this Contract shall constrain the Contractor from engaging in contact with manufacturer personnel on behalf of other Contractor clients.
6. The Contractor shall design, develop, test and implement an electronic interface with the Contractor's POS pharmacy claims processing system to assure timely transmission and uploading (posting) of prior authorization data from the Prior Authorization Call Center to the TennCare-POS pharmacy system.
7. The Contractor shall monitor compliance with the TennCare PDL, report that information to the State monthly, and provide suggestions for improving PDL compliance every quarter to coincide with recommended PAC class criteria reviews.

A.43.b. TennCare PDL Design, Development, and Implementation

1. The Contractor shall use pharmacoeconomic modeling and evidence-based data including, but not limited to therapeutic class reviews, guidelines and reports from the Drug Effectiveness Review Project (DERP) and Medicaid Evidence Based Decisions Project (MED) data in the maintenance of the TennCare PDL that ensures clinically safe and effective pharmaceutical care and yields the highest overall level of cost effectiveness. The Contractor shall develop and submit to the State a schedule for review of the TennCare PDL (including addition of drug classes as appropriate) that meets the State's pharmacy program goals and timelines. The Contractor shall develop and present to the TennCare Pharmacy Advisory Committee the clinical and pharmacoeconomic review criteria the Contractor used to make recommendations regarding preferred and non-preferred drugs and the specific written guidelines/criteria to be used in the administration of the prior authorization of non-preferred drugs.
2. The Contractor's PDL development and criteria shall be coordinated with the Contractor's Prior Authorization Unit to ensure scalable processes and minimize enrollee or prescriber impact including, but not limited to prior authorization forms, web prior authorization, clinical decision models or web imbedded prior authorization trees, and ICD-10 point of sale overrides.
3. The Contractor shall design, develop and implement an ongoing, broad-based educational effort to ensure that prescribers and pharmacists are fully aware of the TennCare PDL and prior authorization requirements. Prior to the program implementation, the Contractor shall submit educational plans to the State for review and approval.

4. The Contractor shall ensure that the TennCare-POS pharmacy claims processing system fully integrates the TennCare PDL and prior authorization programs.
5. For the term of this Contract, the Contractor shall comply with all applicable federal and state statutes, regulations, rules and policy requirements and all applicable administrative rules, statutes, policies and guidelines.
6. The Contractor shall ensure that the TennCare PDL program and TennCare-POS system include provisions for:
 - (a) Prior authorization decisions to be made within twenty-four (24) hours of upon receipt of all pertinent information, and timely notification of the outcome to the prescribing physician, dispensing pharmacy and enrollee;
 - (b) Targeted prescriber and pharmacy provider education, training and information regarding the TennCare PDL prior to implementation of any changes, and ongoing communications to include computer and website access to information; and
 - (c) The Contractor shall ensure that all prescribers and pharmacy providers have timely and complete information about all drugs on the TennCare PDL. The Contractor shall make such information available through written materials, such as facsimile blasts using Contractor's Provider database and via the web portal.
7. The Contractor shall support the management and coordination of all activities related to the maintenance of the TennCare PDL. Activities shall include but not be limited to the following:
 - (a) The Contractor shall present to the TennCare Pharmacy Advisory Committee clinical reviews of new brand-name drugs and new generic drugs for clinical safety and efficacy, and make recommendations regarding possible inclusion in the TennCare PDL, prior authorization criteria for coverage and appropriate quantity limits where applicable.
 - (b) The Contractor shall annually review drugs within chosen therapeutic classes in order to affirm or change the recommendations to the State regarding supplemental rebate strategies.
 - (c) The Contractor shall review drug criteria and recommend proposed changes for the TennCare PDL based on new clinical and pharmacoeconomic information, if requested by the State. The Contractor shall conduct class reviews of all existing therapeutic categories over a time-frame to be co-developed with the State.
 - (d) The Contractor shall continually and proactively review all products for changes in cost information, including increases and decreases in federal rebates as they affect the TennCare PDL.

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

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

implementation. The State shall approve all documents and identify the targeted providers for each notification.

A.43.c. TennCare Step Therapy

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

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

The Contractor shall assure that the Call Center staff shall be available to evaluate prior authorization requests per the standards required in Section A.47 of this Contract. An agreed upon set of edits and PA criteria shall be implemented on the date the Contractor assumes full responsibility for the pharmacy benefits program. Additional edits of this type may be implemented at the State's direction at any point in the term of this Contract without additional cost to the State.

A.43.d. TennCare Pharmacy Advisory Committee

The Contractor shall attend, support and facilitate meetings of the TennCare Pharmacy Advisory Committee (PAC) as necessary to maintain the TennCare PDL. Such support shall include the responsibility to develop drug class reviews, prior authorization criteria, quantity limits and step therapy recommendations. The Contractor shall create and maintain records including contact information and duration of each TennCare PAC Committee member's appointment. The Contractor shall coordinate with the State to determine quarterly dates for the PAC meetings. The Contractor shall also be responsible for arrangements and costs for meeting facilities, distribution of meeting materials and preparation of meeting minutes. At the State's request, the Contractor shall create and maintain a contingency plan in accordance to sunset rules of the State. No less than twenty-one (21) business days prior to the scheduled PAC meeting, the Contractor shall have the meeting materials approved by the State and distributed to committee members. Meeting minutes are to be taken by Contractor and the draft copy shall be available for review by the appropriate State staff no more than four (4) weeks after the scheduled PAC meeting. After approval, the draft minutes shall be disseminated to PAC members for approval at the next regularly scheduled PAC meeting. After approval of the minutes they shall be posted on the TennCare and Contractor's dedicated websites. The TennCare Pharmacy Advisory Committee make up and duties may be found at Tennessee Code Annotated (TCA) § 71-5-2401, *et seq.*

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

1. The primary function of the drug class review is to assist the State and the TennCare Pharmacy Advisory Committee members in determining if the drugs within the therapeutic class of interest can be considered therapeutic alternatives.
2. PDL reviews are therapeutic comparisons - PDL drug class reviews should assess a drug or class's place in therapy, including comparisons to other drugs outside the drug class in question.
3. The PDL reviews may also make recommendations for other program initiatives such as development of DUR criteria, prospective edits, step therapy edits and prior authorization.
4. The Contractor shall monitor compliance by prescribers and pharmacists with the TennCare PDL, report that information to the State monthly, quarterly, and semiannually, and provide suggestions for improving PDL compliance.
5. Meeting facility costs as well as audio visual costs, meals, production, and postage will be paid by the Contractor.

A.43.e. TennCare Rebate Administration

The Contractor shall process, invoice and collect federal (OBRA, CMS) and supplemental rebates through the Contractor's rebate administration systems, and shall assume all responsibility for uncollected receivables for each TennCare PBM Program at Go Live for each program. The Contractor's system shall be capable of payment tracking and reconciliation and dispute resolution for disputes related to federal and supplemental rebate unit issues and utilization. The Contractor shall import historical quarterly rebate data into their rebate management system, provided by the State's current rebate vendor. The Contractor shall assume all administrative and management tasks associated with rebates for historical quarters as well as future quarters occurring during the contract period. The Contractor shall generate and issue quarterly invoices for federal and supplemental rebates. The Contractor shall provide the designated State staff data files that contain the specific information and in the specified format as required by the State. The quarterly rebate invoices shall be generated for all pharmaceutical manufactures and State approval by thirty (30) days after the receipt of the quarterly CMS file for supplemental rebates and by sixty (60) days for federal rebates.

The Contractor shall accept medical claims data from the State including but not limited to, current procedural terminology codes, in a format mutually agreed upon by both parties, and shall submit paid claims for physician-administered drugs for federal and supplemental (if applicable) rebates. Contractor shall assume all of the same responsibilities for the submission and collection of federal and supplemental rebates for physician-administered drugs as outlined in the preceding paragraph.

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

The Contractor shall ensure that written notifications are sent to Drug Manufacturers concerning past-due rebate payments for undisputed account balances. Past-due balances shall be identified when they are at forty-five (45), seventy-five (75) and ninety (90) days of delinquency. Notifications shall be issued within five (5) days of delinquent date for supplemental rebates. The State shall be copied on all past-due notifications. The Contractor shall ensure that all drug manufacturers are charged interest as stipulated in each supplemental drug rebate contract and shall send notices to remind the drug manufacturers that interest shall be assessed on all past due accounts as stipulated by their contract with the State. The Contractor shall provide the State with monthly reports, due ten (10) business days after the end of the month for the reporting period, detailing past-due notifications sent to drug manufacturers.

Dispute resolution pertaining to units billed for supplemental rebates shall be done by the Contractor based on unit resolution performed on CMS Rebates. The Contractor shall perform all dispute resolution activities with pharmaceutical manufacturers pertaining to supplemental rebate calculations and collections. The Contractor shall present for State approval remedies for all disputes within ninety (90) days of dispute. The State shall have final approval of all settlements negotiated.

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

The Contractor shall provide to the agency or business of the State's choosing, any and all appropriate, accurate, and balanced pharmacy level claims data needed to resolve or avoid any Medicaid or supplemental drug rebate disputes. This pharmacy level claims data shall be provided within fifteen (15) business days of the request by the State.

1. TennCare Supplemental Rebates

- (a) The Contractor shall negotiate supplemental rebates through an open competition process within specific drug classes, thereby encouraging maximum participation among manufacturers. The Contractor shall negotiate supplemental rebates with pharmaceutical manufacturers as part of the TennCare PDL program. The resulting contract, negotiated by the Contractor and approved by the State, regarding supplemental rebates shall be between the pharmaceutical manufacturer and the State. The Supplemental Rebate Contract shall be written using the template that is approved by the State of Tennessee's Department of Commerce and Insurance and CMS. Such agreements shall be in a format agreed to by the State and approved by CMS. Modifications to the template may be made by the State upon the request by the PBM to allow for non-standard supplemental rebates, for example a performance measure based rebate. The State shall review and approve agreements before execution. The Contractor shall establish and operate a process for accurate reporting and monitoring of negotiated supplemental rebate payments and perform all supplemental rebate dispute resolutions to maximize collections for the State.
- (b) The Contractor shall include diabetic supplies such as syringes, lancets, strips, glucose control solutions and glucose testing monitors in the TennCare-POS pharmacy claims processing system and PDL. For this category, the Contractor shall provide the State a class review, preferred product recommendation and supplemental rebate offer similar to that provided for pharmaceutical agents.
- (c) The Contractor, if required by the State, shall provide annual opportunities for manufacturers to amend supplemental rebate agreements. However, nothing in this Contract shall prevent a manufacturer from offering supplemental or enhanced rebates or amendments to existing supplemental rebates at any time. Contractor shall present all offers, including those that are off-cycle, from all manufacturers to the State regardless of the significance of the offer. The Contractor shall report to the State, on a time schedule and in a format specified by the State, the results of those negotiations and their clinical and fiscal impact on the PDL. The State shall have final approval on all supplemental rebate agreements and amendments.
- (d) The Contractor shall, concurrent with the development of the PDL, conduct meetings with the State to develop and analyze the different potential

supplemental rebate strategies with the designated pharmaceutical manufacturers.

- (e) The Contractor shall provide the State with access to all supplemental rebate contracts and related documentation. This shall include quarterly analysis by therapeutic category including the net cost per drug entity in the category including the demonstration of how that net cost was achieved. This report shall include all Therapeutic Categories, regardless of whether Supplemental rebates are paid or not.
- (f) The Contractor shall ensure that supplemental rebates are in addition to federal rebates as required by Section 1927 of the Social Security Act and complies with CMS guidelines, regulations and policies.
- (g) The Contractor shall maintain the State's supplemental rebate contracts confidentially and separate from its other clients. The Contractor shall propose a plan for securing and maintaining the supplemental rebate contracts and related confidential information in a format agreed to by the State. The State shall approve confidentiality agreements.
- (h) The Contractor shall perform supplemental rebate calculations including National Drug Code (NDC) information and invoice the manufacturers within thirty (30) days after receipt of the quarterly CMS file. The invoices shall be approved by the State and contain information sufficient to minimize disputes and comply with supplemental rebate contracts.
- (i) In a format agreed to by the State, the Contractor shall provide to the State monthly and on request reports (ORRs) on the performance of the TennCare PDL and supplemental rebates.
- (j) The Contractor shall consider a variety of potential rebate strategies and shall compare and contrast for the State the clinical and economic ramifications of each strategy for the State.
- (k) For the term of this Contract, the Contractor may, on behalf of the State and with the prior approval of the State, assemble or join a multi-state pharmaceutical purchasing coalition or cooperative in order to maximize the State's purchasing power.
- (l) Inclusion into the State's PDL shall be based on lowest net cost to the State in a product category over a two (2) year projection, and not highest supplemental rebate achievable.
- (m) In cases where a product has demonstrated a clear clinical superiority, as defined by the TennCare Pharmacy Advisory Committee majority vote and State agreement, that product shall receive PDL status regardless of supplemental rebates.
- (n) In cases where a product has demonstrated a clear clinical inferiority, as defined by the TennCare Pharmacy Advisory Committee majority vote and State agreement, that product shall receive non-PDL status regardless of supplemental rebates.
- (o) During PDL transition a minimum of three (3) months and maximum of six (6) months shall be required to transition users of maintenance medications to different PDL agents. During their negotiations with pharmaceutical manufacturers, the Contractor shall make all attempts to include contract language which requires the manufacturer to continue to pay supplemental

rebates during transitions from the placement of their product, to another manufacturer's product on the PDL,

- (p) All efforts shall be made to not change PDL status within drug categories except every two (2) year period of time to minimize enrollee inconvenience.
- 2. Transfer of TennCare Federal and Supplemental Rebate Contracts. Upon termination of this Contract for any reason, the Contractor shall, at no additional cost to TennCare, allow the State and/or the Contractor, as applicable, to transfer all existing pharmaceutical rebate contracts to TennCare's incoming PBM contractor. Contractor shall also assist in the timely and accurate transition of the work being performed by Contractor relating to the existing pharmaceutical rebate contracts to TennCare's incoming PBM contractor to ensure that there is no gap for the State in receiving pharmaceutical federal and supplemental rebates pursuant to the existing pharmaceutical rebate contracts. The Contractor shall also provide the State with a final accounting of federal and supplemental rebates received through the termination date of this Contract and detailed information regarding federal and supplemental rebates that will be payable for these contracts following the termination date of the Contract.

A.44. TennCare PBM Program Technical Requirements

A.44.a. TennCare MMIS Interface. Operation of the TennCare-POS system requires ongoing interfaces with MMIS. The Contractor shall coordinate with the State to design and maintain an effective interface between MMIS and the Contractor's system for pharmacy claims processing, Pro-DUR and financial systems.

- 1. In order to ensure the security and confidentiality of all transmitted files, the Contractor shall have a system that establishes a dedicated communication line connecting MMIS to the Contractor's processing site. The cost of this communication line is to be borne solely by the Contractor. This dedicated communication line shall meet specifications of the Division of TennCare, STS and the State of Tennessee, including but not limited to the following:
 - (a) All circuits, circuit terminations and supported network options are to be coordinated through the TennCare Director of Information Services, 310 Great Circle Road, Nashville, Tennessee 37243.
 - (b) Contractor shall contact the TennCare Director of Information Services before placing all line orders.
 - (c) Contractor shall provide compatible mode table definitions and NCP configurations for all non-standard system generations.
 - (d) Contractor shall supply both host and remote modems for all non-State initiated circuits.
 - (e) Dial-up access into production regions shall be prohibited.
- 2. After the pre-implementation conversion process, transaction data that changes baseline MMIS files shall be transferred to the Contractor's system on a daily basis unless the State approves a less frequent schedule. The system design shall be finalized during the DDI phase and shall result in the daily update of the TennCare-POS system with the most current information from MMIS. This may include, but not be limited to: recipient eligibility, prior authorization information, provider, and reference information.
- 3. The format of the data exchange shall be determined during DDI and shall resolve any incompatible data format issues that may exist between the Contractor's system

and MMIS. MMIS may be modified to expand certain fields. Although no significant changes to MMIS file structures are anticipated, the MMIS may be enhanced to improve data compatibility between the POS environment and MMIS. The Contractor shall make changes as needed, at no cost to the State.

4. Daily batch files shall be transmitted from MMIS to the Contractor and from the Contractor to MMIS. The transmission from MMIS shall contain, but not be limited to: recipient and provider eligibility records, claim history, prior authorization information and drug formulary information (Procedure Formulary File or PFF). The recipient identification number is currently a nine (9) byte record and is the key indicator for the eligibility record, but this is subject to change at CMS's direction. This number is constant for a given recipient. The transmission of data from the Contractor to the MMIS shall contain records of processed, adjudicated and paid claims.
5. The Contractor shall notify the State, in a manner agreed to by the State each time a file is received from the State in order to verify transmission and receipt of the files.

A.44.b. TennCare POS Network (TennCare POS) Interfaces.

1. At initial system implementation, data transmissions between the TennCare-POS system and the pharmacy providers shall be in National Council on Prescription Drug Programs' (NCPDP) most current version. As updates to the NCPDP format become available, the TennCare POS Contractor shall maintain compatibility both with Providers using the updated version and those using the superseded versions. Compatibility maintenance for each superseded version shall continue until the updated version becomes generally available and the State has approved discontinuation of such maintenance.
2. The Contractor shall support pharmacy providers in their interaction with the TennCare-POS and coordinate with Network vendors to ensure smooth operation of the TennCare-POS with the commercial pharmacy POS environment. The Contractor shall establish testing procedures and certify pharmacy provider practice management systems (i.e., "switches") as compatible and ready to interface with the TennCare-POS. The Contractor shall not be required to supply hardware or software to pharmacy providers.
3. The Contractor shall develop, maintain and distribute to pharmacy providers a pharmacy procedure and billing manual. Manuals shall be posted on the Contractor's dedicated TennCare website and distributed to pharmacies with acknowledgement of Network participation. The manuals shall provide instructions to providers regarding the process by which the provider receives payment, in order to diminish the potential for incorrect billing and the need for adjustments or recoupments. The content of the manuals shall be approved by the State before distribution.
4. The Contractor may not use its position as the TennCare pharmacy claims processing agent to create barriers to providers, or pharmacy practice management vendors who wish to participate in the TennCare-POS. The Contractor shall not charge connection or access fee to pharmacies or switching companies.
5. Federal regulations require the State to maintain appropriate controls over POS eligibility Contractors who perform both switching services and billing services. Switch and billing agent functions, if provided by the same company, shall be maintained as separate and distinct operations. If the Contractor acting as the TennCare-POS Contractor also provides services as the providers' agent, an organizational "firewall" shall be in place to separate these functions.

A.44.c. TennCare Batch Claim Submission Format and HIPAA Compliance.

1. Pharmacy Providers approved by TennCare to submit batch claims shall use NCPDP format for submission of pharmacy transactions. The X12 837 Standard Claim format, or such other format as may be directed by the State in writing, may be used at some point to allow institutional and professional claims to be submitted in batch electronic claim format so long as the batches are compliant with standards and formats published by the State, including the X12 837 and NCPDP formats promulgated by the Secretary of Human Services as specified by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
2. The Contractor shall coordinate with the State to ensure that the electronic formats used for the TennCare-POS conform to present and future regulations as they exist during the term of this Contract. If federal or State laws, rules, regulations or executive orders impose new or different requirements regarding electronic formats during the term of this Contract, Contractor shall carry out any necessary work to establish compliance at no additional cost to the State.

A.44.d. TennCare POS Interface Software. The Contractor shall provide software to allow the State to test the Contractor's system through the TennCare Network. During the DDI Phase, the State shall test submission and receipt of NCPDP point-of-sale transactions. After implementation, and during the term of this Contract, the State or its contractor shall test and audit performance of the system. An ongoing project plan shall be required to coordinate a software release schedule and detail how TennCare and/or MMIS efforts are to be coordinated.

A.44.e. TennCare POS System Availability Requirements. The Contractor shall ensure that the cumulative system downtime shall not exceed two (2) hours during any continuous five (5) day period.

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

A.44.f. TennCare System Maintenance and Modification Deadlines and Damages. System maintenance problems shall be corrected within five (5) business days or by a State-approved correction date.

A.44.g. TennCare System Security Requirements. The Contractor shall apply recognized industry standards governing security of State and Federal Automated Data Processing systems and information processing.

1. Contractor shall complete a Security Assessment conducted by TennCare or a third party designated by TennCare for this purpose. To the extent that the Security Assessment identifies any material risks or deficiencies for which remediation is required, such remediation requirements or compensating controls must be completed within six (6) months for Moderate risk items or one (1) month for High risk items. A TennCare security exception must be requested for any remediation measures exceeding these timelines. Contractor's failure to complete any remediation requirements set forth within the required timeframe or without an exception for an extension shall be deemed to be a material breach of the Agreement.
2. If Contractor has a Health Information Trust Alliance (HITRUST) Common Security Framework (CSF) Certification applicable to the services and/or applications in scope for the Contract and maintains such certification throughout the period of the Contract, then that HITRUST certification will be accepted in lieu of a separate TennCare assessment. To the extent the Contractor does not have HITRUST CSF certification prior to the start of the Contract it must initiate the certification process within ninety (90) days of the start of the Contract and obtain and provide to

TennCare such Certification within twenty-four (24) months of the start of the Contract. Other major industry standard certifications with appropriate coverage and validation may be accepted at TennCare's discretion.

3. Contractor shall promptly (within thirty (30) days of identification) report to TennCare Information Security any findings and associated corrective action plans identified during a self-assessment or any third party assessment. Contractor will provide TennCare with any further information associated with such findings, as requested in writing by TennCare.
4. If the Contractor uses cloud based services for the processing or storage of TennCare data, this is required to be in a FedRAMP Certified Moderate environment. The certification must be provided in conjunction with the effective date of this agreement and as part of a TennCare Security Assessment request. Should data transfer be necessary between a cloud service and TennCare systems, the transfer must be to a static IP address for the cloud provider. Should the Contractor make a change in an existing cloud service or an initial change to a cloud service during the course of the Contract, this would represent a significant change and require a new Security Assessment. In order to allow time for necessary internal and external approvals, this assessment must be completed 3 months prior to any change in current services and subject to all appropriate federal approvals based on the data being utilized in the cloud service. The following TennCare requirements apply to cloud environments:
 - (a) The use of a multi-tenant environment is prohibited for hosting TennCare Confidential Information, unless TennCare Information Security provides written approval for such an arrangement.
 - (b) The Contractor shall provide a detailed mechanism for how retention will be implemented and meet TennCare policies and requirements. This includes how metadata will be created, accessed, and stored in the cloud environment.
 - (c) Incident response roles and responsibilities must be clearly outlined between the Cloud Service Provider (CSP) and TennCare or CSP and Contractor, as appropriate.
 - (d) The CSP shall be able to enforce the account management capabilities, such as account lockouts for unsuccessful logon attempts, defined inactivity times, remote access allowances, specific success and failure events, including audit trails for multiple failed log in attempts and management of elevated privilege accounts.
5. At a minimum, the State requires the Contractor to conduct a security risk analysis and the results shall be included in the Information Security Plan provided during the DDI phase. The risk analysis shall also be made available to appropriate Federal agencies upon request. As determined by the State to be appropriate, the following specific security measures shall be included in the system design documentation, operating procedures and State agency security program requirements:
 - (a) Computer hardware controls that ensure acceptance of data from authorized networks only;
 - (b) Computer hardware controls that ensure proper use, sharing, and inability to store client PHI and PII without express authorization or as defined in their role.

- (c) Placement of software controls, at the Contractor's central facility, that establish separate files for lists of authorized user access and identification codes;
 - (d) Manual procedures that provide secure access to the system with minimal risk;
 - (e) Multilevel passwords, identification codes or other security procedures that shall be used by State or Contractor personnel;
 - (f) All TennCare-POS software changes subject to the State's approval prior to implementation; and
 - (g) System operation functions segregated from systems development duties.
6. Contractor shall complete a third-party penetration test every three hundred sixty-five (365) days or in the event of a major change in the system. All medium, or higher, risk findings shall be communicated to TennCare Security within one (1) week of the finding. The testing shall, at minimum, include the SANS top ten (10) for the application and database servers with both automated and manual evaluation methods. A penetration testing report must be sent to TennCare Security prior to "go-live".

A.44.h. TennCare Proprietary and Confidential Information.

1. All proprietary information, including but not limited to, provider reimbursement information provided to the State, shall be deemed confidential and not subject to disclosure under the Tennessee Public Records Act. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of federal law, State law, and ethical standards and shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with federal law, State law and ethical standards. Confidential information includes any non-public, confidential or proprietary information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, which is supplied by the State to the Contractor or acquired by the Contractor on behalf of the State under this Contract.
2. TennCare Confidentiality of Records and Duty to Protect. Strict standards of confidentiality of records shall be maintained in accordance with federal and state laws and regulations and TennCare policies, procedures and rules. The Contractor shall exercise the same or greater level of care to preserve the confidentiality of the State's information as the Contractor exercises to protect its own confidential information so long as such standard of care does not violate the applicable provisions of the first paragraph of this section. Confidential Information (i) shall be held by the Contractor in strictest confidence at all times; (ii) shall not be disclosed or divulged by the Contractor to any person or entity, except those employees and agents of the Contractor who require access to such information, and only after those employees and agents have been instructed that the information is subject to the confidentiality obligations set forth herein; and (iii) shall not be used by the Contractor for any purpose not set forth herein or otherwise authorized in writing by the State. Contractor shall diligently exercise the highest degree of care to preserve the privacy, security and integrity of, and prevent unauthorized access to, the Confidential Information. Contractor ensures that it has established written policies and procedures relating to confidentiality, including the confidentiality of protected health information and eligibility information. Contractor ensures that it has implemented administrative, technical and physical safeguards and mechanisms that protect

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

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

A.44.i. TennCare Third Party Administrator Requirement.

1. The Contractor shall qualify as an Administrator (also described as "Third Party Administrator") in compliance with T.C.A. Title 56, as applicable, and shall be licensed to operate as an adjuster or settler of claims in connection with pharmacy benefits coverage in the State of Tennessee and shall be capable of providing or arranging for health care services provided to covered persons for whom it received payment and is engaged in said business and shall do so upon and subject to the terms and conditions hereof.
2. If during the term of this Contract, the State directs the Contractor, through a contract amendment, to operate as a risk-bearing entity for pharmacy services, the Contractor shall establish and maintain all financial reserves required by the Tennessee Department of Commerce and Insurance of HMOs, Third Party Administrator, or Prepaid Limited Health Services Organization licensed by the State of Tennessee, including, but not limited to, the reserves required by TCA § 56-32-112 as amended or Tennessee Code Annotated § 56-51-136 as amended. The Contractor shall demonstrate evidence of its compliance (or process of compliance) with this provision to the Tennessee Department of Commerce and Insurance, TennCare Division, in the financial reports filed with that Department by the Contractor.

A.44.j. TennCare Member Identification Cards.

1. The Contractor shall provide each TennCare member with permanent pharmacy benefit identification (ID) card. This shall occur at least three (3) weeks prior to the commencement of the Contractor processing claims. The card shall comply with all state laws and NCPDP guidelines, as amended, regarding the information required on the card, as well as any other information required by the State, and must be approved by the State. In no event shall the Contractor print or otherwise include the

individual TennCare enrollee's Social Security Number on any identification card required for the individual to access products or services provided under this Contract. The Contractor shall provide pharmacy benefit identification cards for new TennCare members added to the TennCare eligibility file on an ongoing basis. The Contractor shall establish a process that allows enrollees to request replacement cards. Replacement and new cards shall be produced and mailed by the Contractor on the 15th day of each month.

2. The Contractor shall establish and maintain a process to produce ID cards for new enrollees and issue replacement ID cards upon request from a TennCare enrollee. The Contractor shall be reimbursed for actual postage costs. Such costs shall be billed on a monthly basis to the State in addition to regular invoices and shall include substantiating documentation. The cost related to the production of the identification cards shall be included in the Contractor's base rate in this Contract.
3. Other mailings pursuant to this Contract shall be mailed first class unless otherwise directed by the State. The actual postage cost shall be a pass-through item and shall be billed on a monthly basis to the State in addition to regular invoices and shall include substantiating documentation. Printing and supply costs are to be included in the base rate of this Contract. The Contractor shall not invoice the State for Contractor business operations.

A.44.k. TennCare Returned Mail. The Contractor shall open all returned mail from any mailings to enrollees or providers within thirty (30) days of receipt to determine if the enrollee is communicating other information to the Contractor or to the State. The Contractor shall track returned mail and shall report monthly to the State the number of pieces of returned mail, the reason the mail was returned and action taken by the Contractor. This monthly report is due ten (10) business days after end of month of reporting period, beginning the first full month after the report format has been agreed to by all parties. Nothing in this section shall prevent the Contractor from sub-contracting responsibilities for returned mail to a vendor approved by the State.

A.44.l. TennCare Website. The Contractor shall develop and maintain a State approved up-to-date web-site dedicated to the TennCare Program that shall aid providers and enrollees in all aspects of the pharmacy program. The web-site shall be available for the State's approval at least three (3) months prior to the commencement of claims processing and be available on the internet two (2) weeks prior to the commencement of claims processing. The web-site shall contain a home page with general pharmacy information with links to dedicated areas for prescribers, pharmacists and enrollees. Each of these sections shall contain information that shall answer, in an interactive format, the majority of questions that each group would ask. This shall include, but it not limited to:

1. Home Page, which includes:
 - (a) General information related to pharmacy benefits, and recent changes occurring within the TennCare Pharmacy Program, including pertinent fact sheets;
 - (b) Access to an interactive Preferred Drug List (PDL) with links to Covered OTCs Lists, Clinical Criteria, Step Therapy criteria, Quantity Limits, Auto-exemption and Provider Attestation lists, and Prior Authorization Forms;
 - (c) Civil rights language and links; and
 - (d) Provider Log-in/Register access and features to access Web PA (prescribers)
2. Prescriber Page, which includes:

- (a) An interactive preferred drug list (PDL) of the TennCare pharmacy program, complete with hot links from drugs to the prior authorization (PA) criteria established for those drugs and also linked to drug specific PA facsimile forms and drug specific web-based PA application;
 - (b) A search function which allows providers to enter a drug name and be routed to the drug in the interactive PDL;
 - (c) Procedures for obtaining Prior Authorizations (PA's);
 - (d) Call Center hours of operation and contact numbers;
 - (e) Printable education material specific to prescribers; and
 - (f) Access to Web Prior Authorization tools and automated overrides
3. Pharmacist Page, which includes:
- (a) An on-line listing of all products and current pharmacy reimbursement for each product (e.g. Actual Acquisition Cost, Average Acquisition Cost, NADAC, and CMS' FUL) to be updated on a weekly basis. Such listing may be provided as a link to TennCare's AAC vendor, if possible and if such vendor is used by the State; and
 - (b) Printable on-line pharmacy handbook and Provider Education Material specific to Pharmacist.
 - (c) Patient forms:
 - (1) Prior Authorization Required Form (PARF) (English and Spanish)
 - (2) Tamper Resistant Denial Notice (English and Spanish)
 - (d) An interactive preferred drug list (PDL) of the TennCare pharmacy program, complete with hot links from drugs to the prior authorization (PA) criteria established for those drugs and also linked to drug specific PA facsimile forms and drug specific web-based PA application;
 - (e) A search function which allows providers to enter a drug name and be routed to the drug in the interactive PDL;
 - (f) Call Center hours of operation and contact numbers;
 - (g) Covered OTC list, updated at least twice annually
4. Enrollee Page, which includes:
- (a) A description of services provided including limitations, exclusions and out-of-Network use;
 - (b) Frequently Asked Questions that answer questions regarding what to do if the enrollee is unable to fill a prescription because PA is required, but has not been obtained, including information on the enrollee-initiated PA process;
 - (c) Printable education material specific to enrollees; and
 - (d) On-line search, by address or zip code, to locate the Network pharmacies nearest to the enrollee.

5. Committee Tab, which includes:
 - (a) DUR. A list of current TennCare DUR Advisory Board Members, future and archival meeting dates, agendas, presentations, and meeting minutes.
 - (b) PAC
 - (1) A list of current TennCare Pharmacy Advisory Committee Members, future and archival meeting dates, agendas, packets or presentations, proposed review schedule, meeting minutes, and subcommittee meeting materials.
 - (2) Active links to relevant rules, laws, request for drug class review, and public testimony.
 - (3) Contractor shall provide a method for Member, Provider, or industry personnel to submit requests for public testimony electronically. Similarly, the Contractor shall provide a method for Committee Members to submit class review requests electronically.

A.44.m. TennCare Contractor's System – General. The Contractor's system shall be a secure, HIPAA-compliant and data-encrypted electronic system. The system shall have the ability to be easily customized and have interactive communication capabilities to meet the needs of TennCare and its providers. The Contractor shall provide support and maintenance of the website and guarantee any data exchange between the Contractor and TennCare or its providers and enrollees shall be secure and compliant with current HIPAA guidelines concerning data encryption and/or password protection. The State shall transmit TennCare eligibility/enrollment information to the Contractor Monday through Friday, excluding State holidays, by the standard HIPAA 834 Transaction defined by the TennCare Companion Guide. The Contractor shall load and apply this information to daily to identify those enrollees who have no limits, have no pharmacy benefit, are subject to limits, or subject to copays, and make necessary systems changes to process claims accordingly. The NCPDP 4.5 formats shall be used for encounter reporting sent to the State.

A.44.n. The Contractor shall accept enrollees in the order in which applications are approved and enrollees are assigned to the Contractor (whether by selection or assignment). The Contractor shall accept an enrollee in the health condition the enrollee is in at the time of enrollment and shall not discriminate against individuals on the basis of health status or need for health care services.

A.44.o. Disenrollment. A member may be disenrolled from the Contractor's PBM only when authorized by TennCare. The Contractor shall not request disenrollment of an enrollee for any reason. The Contractor shall not disenroll members for any of the following reasons:

1. Adverse changes in the enrollee's health;
2. Pre-existing medical or behavioral health conditions;
3. High cost medical or behavioral health bills;
4. Failure or refusal to pay applicable TennCare cost sharing responsibilities, except when this results in loss of eligibility for TennCare;
5. Enrollee's utilization of medical or behavioral health services;
6. Enrollee's diminished mental capacity; or
7. Enrollee's uncooperative or disruptive behavior resulting from his or

her special needs (except when his or her continued enrollment in the PBM seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).

A.45. TennCare Retrospective Drug Utilization Review and Provider Education

A.45.a. TennCare Retrospective Drug Utilization Review (Retro-DUR)

The Contractor shall provide to the State all necessary components of a TennCare Retro-DUR program as required in 42 CFR 456.709: "for ongoing periodic examination (no less frequently than quarterly) of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid recipients, or associated with specific drugs or groups of drugs. This examination must involve pattern analysis, using predetermined standards of physician prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies. The Contractor's Retro-DUR system's intervention processes shall include, at a minimum, letter-based information to providers and a system for tracking provider response to the interventions. The Contractor shall prepare, for the State's approval, provider letters containing information related to the operation of the TennCare pharmacy program.

The Contractor shall provide a dedicated DUR Clinical Pharmacist, who shall be a Tennessee-licensed pharmacist and dedicated 100% to the TennCare program, and who shall prepare presentations and attend each quarterly meeting of the TennCare DUR Board to present Prospective DUR (Pro-DUR) and Retro-DUR data, findings, and utilization data, along with a class review at each meeting, using TennCare paid and denied claims, TennCare diagnosis and procedure codes and information gathered from the State of Tennessee's Controlled Substance Monitoring Database. In addition, the Contractor's dedicated DUR Clinical Pharmacist shall be responsible for the organization of DUR Board meetings, including presiding at the meeting, preparing a PowerPoint presentation for each meeting, and working with the State to determine the agenda and content of each meeting.

The DUR Clinical Pharmacist shall be dedicated solely to the gathering of data, analysis of results, developing recommendations and presentation of such to the State and the TennCare DUR Board. The DUR Clinical Pharmacist shall schedule and conduct a Pre-DUR meeting with appropriate State staff no less than four (4) weeks prior to the scheduled meeting. This pharmacist shall be outside the scope of the Contractor's Key Staff described in Section A.7. No less than ten (10) business days prior to the scheduled DUR meeting date, the DUR Clinical Pharmacist shall present to the State the proposed agenda and meeting materials for approval and later posting on the TennCare and Contractor's websites in compliance with Open Meetings Act (Sunshine Law) as defined in TCA § 8-44-101 *et seq.* No greater than two (2) weeks after the DUR meeting, the DUR Clinical Pharmacist shall schedule a Post-DUR meeting with appropriate State staff. No greater than four (4) weeks after the DUR meeting the meeting minutes shall be available for review.

The Contractor shall also implement a complete Retro-DUR program to be coordinated and maintained by the full-time DUR Clinical Pharmacist dedicated to TennCare and supported by the Provider Liaison Pharmacists who are Tennessee-licensed pharmacists, and additional clinical reviewers who are also Tennessee-licensed pharmacists.

1. Description of the Operation of the TennCare Retro-DUR Program -The Contractor shall provide to the State all necessary components of a Retro-DUR program and shall operationalize those as specified in 42 CFR 456.716:
 - (a) Operation of a Drug Utilization Review (DUR) Board as follows:
 - (1) The Contractor shall determine quarterly dates for the DUR Board meetings, schedule the meeting location and provide food and beverages for board members attending the meeting. Minutes for

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

- i. TennCare utilizing-members data;
 - ii. TennCare utilization by age demographics;
 - iii. TennCare utilization by top ten (10) therapeutic classes determined both by number of claims and by payment amount;
 - iv. TennCare top ten (10) drugs as ranked by claim count and by total payment;
 - v. Pro-DUR data including totals of Pro-DUR messages sent and savings associated with the top ten (10) drugs associated with each Pro-DUR edit;
 - vi. Retro-DUR intervention analysis and cost savings information as associated with both member profile review and interventions and provider profile review and interventions;
 - vii. Reports and presentations should convey rolling twelve (12) month trends;
 - viii. Distribution of Clinical Alerts as prepared monthly by the Contractor's Clinical Management staff;
 - ix. Pharmacy lock-in summary level reports, and
 - x. Additional reports, as requested by the State or the DUR Board.
- (2) The primary role of the DUR Board shall be to provide program oversight and advice concerning provider education initiatives and current or proposed DUR POS edits outlined in 42 CFR § 456.716. The DUR Board shall not be involved with PDL coverage decisions, but may make referrals to the TennCare PAC based on decisions made due to trends found in RDUR activities, and shall be notified of current PDL changes; and
- (3) The Contractor shall send all DUR Board members a letter explaining that the responsibility for the Retro-DUR program is being transitioned to the Contractor. New members shall receive a Letter of Appointment that specifies the lengths of the appointment term.
- (b) Recruit, maintain, and reimburse a panel of clinical pharmacists sufficient to review member profiles as noted in subsection e. below. The clinical pharmacists shall recommend appropriate interventions related to each profile reviewed.
- (c) With input from the State and the DUR Board, the Contractor shall determine the focus of and generate data above for each of four (4) quarterly provider profile runs and each of twelve (12) monthly member profile runs. Quarterly provider profile reviews shall be completed and results/interventions distributed to prescribers within ninety (90) days of the end of the quarter. Monthly member profile reviews shall be completed and results/interventions distributed to prescribers within sixty (60) days of the end of the month.

- (d) After approval by the State of the focus of, and methodology to be used in, the member profile reviews, the Contractor shall produce eight hundred (800) member profiles per month, or a minimum of two thousand four hundred (2,400) member profiles per calendar quarter, and distribute to clinical reviewers for review and determination of appropriate interventions to be taken. Any summaries, correspondence or other documents produced as a result of the review process shall be approved by the State prior to their distribution.
- (e) After approval by the State of the focus of, and the methodology to be used in, the provider profile reviews, the Contractor shall produce two thousand four hundred (2,400) provider profiles per calendar quarter and determine appropriate interventions to address any potential problems identified during profile review. Unlike member profiling, provider profiles need not be reviewed by clinical reviewers, as they simply detail members for whom a prescriber or pharmacy provider has prescribed or dispensed a medication under review for the calendar quarter.
- (f) Implement interventions designed to address problems identified during profile review. These interventions shall include, at a minimum, mailings sent to prescribers or pharmacy providers, but phone calls or visits may also be conducted if appropriate and/or upon the direction of the State. Mailings shall consist of an intervention letter to the prescriber or pharmacy provider detailing the reason for the letter, the purpose of the intervention and providing educational information. Member profile(s) illustrating the potential problem and suggesting corrective action may also be included, along with a provider response form seeking input for the value of the intervention. The postage associated with these mailings shall be reimbursed by the State as a pass-through cost. Interventions regarding possible fraud and abuse shall be reported to the State.
- (g) Maintain a system that complies with all requirements of Section A.45.b below, capable of tracking all interventions, both letters and direct communication, and determining cost savings related to the specific interventions. This system shall also record input received from providers regarding the value of the intervention.
- (h) The Contractor shall establish and maintain a toll-free telephone number and voice mail box to receive provider responses to Retro-DUR notices. The DUR Clinical pharmacist shall be responsible for management of call backs from the inquiries received through this telephone number and voice mail box.
- (i) Report twice yearly to the DUR Board on monthly member reviews and quarterly provider reviews to include interventions taken, responses, and outcomes.
- (j) Produce an Annual Drug Utilization Review Report for the TennCare program using the annual CMS requirements as stated in 42 CFR § 456.712.
- (k) The State or DUR Board may request additional reports as needed to conduct business as provided herein.

A.45.b. TennCare Retro DUR Reporting System

1. The Contractor shall provide a reporting system that tracks the outcomes of the Retro DUR initiatives. TennCare's Retro DUR initiatives are mainly focused on improving care quality. The Contractor's system shall be able to track the impact of DUR initiatives by comparing specified data elements pre and post intervention. The data

elements tracked will vary according to the focus of study and/or type of intervention employed and may include, but shall not be limited to:

- (a) Drug change within a sixty (60) or ninety (90) day period of the intervention;
- (b) Total number of drugs pre- and post- intervention;
- (c) Change in dose/dosing frequency of medication within a sixty (60) or ninety (90) day period of intervention;
- (d) Daily dose of drug in question pre- and post- intervention;
- (e) Assessment of various interactions (as relevant to the activity) pre- and post-intervention which may include drug-drug interactions (e.g., number of drugs identified and severity index), pregnancy interactions, disease state interactions, therapeutic duplications, allergy interactions, and age-related medication problems;
- (f) Compliance with national guidelines (e.g., percentage of patients with CHF on beta-blocker, diuretic, etc.) depending on the disease state targeted by the RetroDUR initiative;
- (g) Semi-annual Top Controlled Substance Prescribers report card;
- (h) Patient compliance;
- (i) Hospitalizations and/or doctor visits pre and post intervention; and
- (j) Prescription and/or medical costs pre and post intervention.
- (k) Cost savings resulting directly from DUR interventions to be reported to the State on a twice-yearly basis, and included in the Annual CMS report.

A.45.c. Provider Liaison Pharmacists – TennCare Program Duties

1. The Contractor shall develop and implement ongoing educational programs for the TennCare provider community designed to improve provider awareness of TennCare pharmacy program policies and procedures and to assure PDL compliance by prescribers. These educational initiatives shall include, but not be limited to: provider letters, PDL distribution, POS messaging, training sessions, website postings of the PDL and other educational materials for prescribers. Prior to the go-live date the Contractor shall conduct educational meetings for providers in East Tennessee, Middle Tennessee, and West Tennessee. In each calendar year during the term of this Contract, the Contractor shall exhibit at all Tennessee Pharmacist Association (TPA) and Tennessee Medical Association (TMA) meetings with an informational booth, and at The University of Tennessee's Spring Pharmacy Update meetings in all locations.
2. The Contractor shall provide an information plan detailing education to TennCare providers regarding the TennCare PDL and associated prior authorization programs. The Contractor shall provide education and notification processes and methods designed to increase TennCare PDL compliance rates and minimize transition disruptions, and information concerning provision of the seventy-two (72) hour emergency supply in applicable situations.
3. Upon the State's approval, the Contractor shall develop and produce program material to be provided to the State for distribution and supplied directly by the Provider Liaison Pharmacists to provider groups.

4. The Contractor shall implement State approved communication strategies through direct involvement with prescribers and pharmacy providers and a combination of site visits, telephone support, internet-based application, and direct mail.
5. The Contractor shall develop a process or system to capture the activities of the field-based Provider Liaison Pharmacists. On a quarterly basis, the Contractor shall summarize, review and offer recommendations to the State regarding provider education.

A.46. TennCare Prior Authorization (PA) Unit

- A.46.a. TennCare Prior Authorization Unit. The Contractor shall conduct a prior authorization system that complies with the requirements of section 1927(d)(5) of Title XIX of the Social Security Act (the Act), 42 CFR §§ 438.3(s)(6) and 438.210, TennCare rules, and the TennCare approved TennCare PA policies and procedures.

In accordance with §1927(d)(5)(A) of the Act, Contractor's PA system must provide a response by telephone or other telecommunication device within 24 hours of a request for prior authorization.

In accordance with 42 CFR §§ 438.3(s)(6), and 438.210, Contractor must notify the requesting provider of its PA determination, and, if the PA is not approved, issue a Notice of Adverse Benefit Determination (NABD) to the enrollee on whose behalf PA was requested, within (24) hours of receiving all of the information necessary to facilitate the determination.

Contractor shall operate a PA Review Unit, which, at the option of the State, shall include ePA (Electronic Prior Authorization) services. A PA shall be required for all non-preferred drugs or utilization of preferred drugs outside of established guidelines. These established guidelines shall include, but are not limited to: Step Therapy; Clinical Criteria; Pro-DUR edits such as Drug-Gender and Drug-Drug interactions; and quantity limits.

1. Prior authorization services shall consist of prescription review by a licensed pharmacist or pharmacy technician to ensure that all predetermined clinically appropriate criteria have been met before the prescription may be dispensed and subsequently reimbursed. The Contractor's PA process shall comply with the requirements of section 1927(d)(5) of the Social Security Act.
2. A clinical pharmacist shall be on duty twenty-four (24) hours a day, seven (7) days a week (24/7). The PA Unit shall have the capacity to render written and oral clinical decisions in response to provider requests for PA (and in response to provider requests for Contractor to reconsider an adverse PA decision) on a 24/7 basis. Contractor understands that these obligations involve provider requests made on behalf of a population of approximately one million, five hundred thousand (1,500,000) covered lives. The actual number of covered lives may fluctuate and the above figure shall not be deemed to be the maximum number of covered lives that the Contractor's PA Unit will be required to handle.
3. The PA Unit shall accept requests for prior authorization submitted by telephone, facsimile, mail and through a web-based application. All PA determinations shall be based on criteria approved by the State, and any decision to deny a request for PA or to authorize provision of a covered outpatient drug in an amount, duration, or scope that is less than requested shall be made by an individual who has appropriate expertise in accordance with 42 CFR 438.210(b)(3).
4. The Contractor shall be responsible for processing the entire PA transaction and for doing so in accordance with applicable law and State-approved requirements. The PA transaction for which Contractor is responsible includes: rendering PA determinations; resolving enrollee and provider grievances; resolving provider requests for Contractor reconsideration of adverse PA decisions; and issuing PA decision notices, whether

the PA is approved, partially-approved, or denied, both to the requesting provider and to the enrollee on whose behalf the PA was sought. Contractor's PA process flow and notification format shall be approved by the State prior to implementation and before any changes are made by Contractor. The Contractor shall disclose operational criteria and updates to the State on a frequency determined by the State for review and approval.

5. The Contractor shall provide the State with the following information related to lodging PA requests. Contractor shall provide this information at least sixty (60) days prior to the date the Contractor assumes full responsibility for the pharmacy benefits program.

(a) a transfer plan for the toll-free (in-state and out-of-state) telephone and facsimile numbers from the existing TennCare PBM contractor,

(b) mailing address, and

(c) web-site address (URL).

This toll-free number shall be transferable to the State upon termination of this Contract. The Contractor shall distribute the above-noted information to providers at all training sessions. It is anticipated that a significant number of the prior authorization requests for the TennCare PDL and other associated prior authorizations shall be received through the telephone system.

6. The PA Unit shall have a process in place to ensure that written and oral contacts are handled with consistency and efficiency. The PA Unit shall provide an automated call distribution system with a greeting message when necessary and educational messages approved by the State while callers are on hold. The PA Unit shall install and maintain its telephone line in a way which permits calls to be monitored remotely by the State in real-time. The system shall also permit the Contractor to retrieve calls, at the State's request, based on any of the following search factors: date, time, caller's number, or enrollee identification, for the purpose of evaluating Contractor performance. The PA Unit's telephone greeting shall include a message that informs callers that call monitoring is occurring.
7. Call monitoring by a third party, for accuracy and quality of information, shall be available at the Contractor's PA Unit location and from the TennCare main office.
8. The PA Unit shall ensure that there is a backup telephone and fax system in place that shall operate in the event of any interruption in operations lasting 10 (ten) minutes or longer so access to the Prior Authorization Unit by telephone and fax is not disrupted. The Contractor shall notify the State of any system or business interruption that is ten (10) minutes or longer in duration, as required in the TennCare policies and procedures. In no event should the back-up telephone and fax systems be in an offshore site. Within one hour of the time when the Contractor knows or should have known of a system or business interruption that is ten (10) minutes or longer in duration, the Contractor shall notify the State of such problem. Failure to comply with this requirement may result in the assessment of Liquidated Damages in accordance with Contract Section E.10 and Attachment C to the Contract.
9. The Prior Authorization Unit shall provide sufficient telecommunications capacity to meet the TennCare Program's needs with acceptable call completion and abandonment rates as specified in the performance standards below. This capacity shall be scalable (both increases and decreases) to demand in the future.
10. The Contractor shall ensure that qualified personnel responding to prior authorization requests are fully trained and knowledgeable about TennCare standards and protocols, have the capacity to handle all telephone calls, facsimiles and web requests at all times and have the upgrade ability to handle any additional call, facsimile or web

request volume. The Contractor shall be responsible for adequate staffing and equipment at all times, especially during peak times. Any additional staff or equipment needs shall be the responsibility of the Contractor. The Prior Authorization Unit shall provide licensed pharmacists during all hours of unit operation to respond to pharmacy related questions that require clinical interventions, reconsiderations and consultation, and provide physician support for responses to prior authorization and reconsideration requests from providers.

11. The Contractor shall design and implement a contact management and reporting system that, at a minimum, includes electronic recording of all calls and provides a complete record of communication and documents from providers and other interested parties. The Contractor shall provide complete online access by the State to all computer files and databases that support the system for applicable pharmacy programs and develop, maintain, and ensure compliance with TennCare confidentiality procedures/policies, including HIPAA requirements, within the Prior Authorization Unit.
12. The Contractor shall be responsible for a Quality Assurance program that shall be in place to sample calls and follow up calls to confirm the quality of responses, and caller satisfaction. The Contractor shall provide the State with quarterly reports on the outcomes of the Quality Assurance program, and any training required to assure adherence to PA criteria and consistent application of such criteria across all PA Unit staff.
13. The Contractor's staff shall assist the State with the development of clinical prior authorization review criteria. The Contractor shall develop drug-specific prior authorization forms for prescribers to use when sending a request via facsimile or via the web. The prior authorization forms shall be available to prescribers via web download or fax-on-demand. The State shall review and approve the PA request forms prior to distribution by the Contractor.
14. The Contractor shall develop a process by which every request for prior authorization is handled with the same procedure. This may be done by developing an algorithm/hierarchy for every PA that can be requested or other process developed by the Contractor and approved by the State.
15. The Contractor shall meet the following performance standards and is required to provide TennCare reports as described in Attachment D demonstrating that it has performed as follows:
 - (a) The Prior Authorization Unit shall be available twenty-four (24) hours-a-day, seven (7) days-a-week, to respond to prior authorization requests, except for downtime that has been prior approved in writing by the State.
 - (b) The Contractor shall provide sufficient staff, facilities, and technology to maintain service levels within the Prior Authorization Unit such that all calls are answered within thirty (30) seconds on at least twenty-seven (27) days per month, and the abandoned calls shall not exceed two percent (2%) on more than three (3) days per month.
 - (c) Calls shall be answered within thirty (30) seconds. If an automated voice response system is used as an initial response to inquiries, an option shall exist that allows the caller to speak directly with an operator. The Contractor shall provide sufficient staff such that wait time to speak to a live representative shall not be in excess of thirty (30) seconds.
 - (d) All call line inquiries that require a call back, including general inquiries, shall be returned within one (1) business day of receipt one hundred percent (100%) of the time.

16. Activities of the Prior Authorization Unit shall be summarized and reported to the State as described in Attachment D of this Contract.

A.46.b. TennCare Prior Authorization (PA) Process

The Contractor shall ensure that PA decisions are based on all available pertinent information, including the enrollee's prescription history (including paid and denied claims), and available medical history. Contractor's PA decision must account for whether the request is for a prescription drug that is a controlled substance or has potential for abuse. The Contractor shall also query the State of Tennessee's Controlled Substance Monitoring Database (CSMDB) for the enrollee's profile and include the information in the CSMDB in the decision making process when applicable or when requested by TennCare. If the request is consistent with the PA and/or medical necessity criteria approved by the State, the Contractor shall document the request in the Contractor pharmacy case management system and enter an override in TennCare-POS system for the appropriate period of time.

If the request is not consistent with applicable PA criteria, the request shall be referred to a clinical pharmacist in the PA Unit. If upon review, the clinical pharmacist finds sufficient justification for an override, the request and clinical rationale for the outcome shall be documented and an override entered in the TennCare-POS system. If sufficient justification is not evident, this shall be documented and the PA shall be denied. All PA denials must be made with the judgment of a clinical pharmacist.

In accordance with 42 C.F.R. §438.210(d)(3) Contractor must render a PA decision within 24 hours of receiving a PA request for an outpatient drug. If the PA request fails to contain the requisite supporting information (as specified in the applicable clinical criteria), Contractor may request from TennCare additional time within which to issue its PA determination. In no event shall Contractor's PA response timeframe be extended by more than three (3) additional business days.

When Contractor denies a request for PA, the Contractor shall issue both a PA denial notice to the requestor and NABD to the enrollee on whose behalf the PA was requested. Pursuant to 42 CFR § 438.404, the NABD shall explain:

1. The Adverse Benefit Determination the Contractor has made or intends to make.
2. The reasons for the Adverse Benefit Determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
3. The enrollee's right to contest the Contractor's proposed Adverse Benefit Determination by filing a request, consistent with 42 C.F.R. § 438.402(c), for a TennCare appeal (and attendant State fair hearing). Consistent with the CMS approval, TennCare's appeal process does not allow for any Contractor-level appeal process. The Contractor meets its obligations under 42 C.F.R. § 438.402(b) by timely complying with the Reconsideration phase of TennCare's appeal process.
4. The procedures for exercising these rights.
5. The circumstances under which TennCare's appeal process can be expedited and how to request it.
6. The enrollee's right to have benefits continue pending resolution of the TennCare appeal, how to request that benefits be continued, and the circumstances, consistent with State policy, under which the enrollee may be required to pay the costs of these services.

A.46.c. TennCare Prior Authorization Peer-to-Peer Reconsideration

The Contractor shall have a peer-to-peer reconsideration process, administered by a board certified physician, available to providers who wish to challenge adverse prior authorization decisions outside of the TennCare appeal process. This peer-to-peer reconsideration process is distinguished from the Reconsideration phase of the TennCare appeal process. Unlike peer-to-peer reconsideration, which involves a dispute between Contractor and a provider, the Reconsideration phase of the TennCare appeal process occurs only after a TennCare appeal is requested by the enrollee or enrollee's authorized representative and involves a dispute between the Contractor and the TennCare enrollee.

The peer-to-peer PA reconsideration process shall ensure that appropriate decisions are made and communicated to the prescriber within one (1) business day of the initial request by a prescriber. The Contractor shall supply the State with all pertinent information pertaining to reconsideration requests within two (2) business days. The Contractor shall develop policies and procedures regarding the peer-to-peer reconsideration processes. These shall be reviewed and approved by the State prior to implementation. The Contractor shall notify providers of the reconsideration process with respect to re-review of adverse prior authorization decisions. The Contractor shall provide the State with monthly reports indicating the number of peer-to-peer reconsideration requests, analysis and disposition.

A.46.d. Enrollee Grievance and TennCare Appeal Process.

1. Grievance System. Contractor shall have an internal Grievance System in place for TennCare enrollees, as required by 42 CFR 438.402(a)-(b) and 42 CFR 438.228(a).
2. TennCare Appeal Process. TennCare, on written approval from CMS, has delegated back to itself certain aspects of the appeal process set forth under 42 CFR 438 subpart F. Specifically, Contractor will not have its own internal Appeal System for enrollee appeals. Enrollees will not exhaust an internal appeal process with Contractor before being permitted to request a TennCare appeal. Accordingly, the provisions in 42 CFR 438.402 that relate to a Contractor-level appeal system do not apply under this Contract. The Enrollee will be offered these protections through the TennCare appeal process and through the TennCare appeal process' Reconsideration phase.
3. Prior Authorization (PA) Determination Timeframe. In accordance with section 1927(d)(5) of the Soc. Sec. Act, Contractor shall respond to the requesting provider within 24 hours of receiving the PA request. If a provider indicates, or the Contractor determines, that following the 24-hour authorization timeframe could seriously jeopardize the enrollee's life or health or his/her ability to attain, maintain, or regain maximum function, the Contractor must make an expedited service authorization decision and provide notice as expeditiously as the enrollee's health condition requires. If the PA request fails to contain the requisite supporting information (as specified in the applicable clinical criteria) Contractor may request from TennCare additional time within which to issue its PA determination. In no event shall Contractor's PA response timeframe be extended by more than three (3) additional business days.
4. Adverse Prior Authorizations Determinations. Contractor's failure to approve provider's PA request triggers additional requirements. If Contractor denies a provider's PA request, Contractor must notify the requesting provider and Contractor must issue a written Notice of Adverse Benefit Determination (NABD) to the enrollee on whose behalf the PA request was submitted. Contractor's NABD must be issued within 24 hours of receiving a PA request containing the requisite information necessary to render a determination (or sooner, in accordance with the previous paragraph, if the enrollee's health condition requires). The NABD must satisfy the notice content requirements prescribed by 42 CFR §438.404(b) and the notification standards prescribed by 42 CFR §438.10. [42 CFR §438.3(s)(6); 42 CFR §438.210(d)(1); 42 CFR §438.404]

- i. When Contractor is required to provide written notice to enrollee, Contractor shall do so using TennCare approved notice templates as provided by the State.

5. Reasonable Assistance with Contractor's Grievance Process and with the TennCare Appeal Process.

- (a) In accordance with 42 CFR 438.406(a) and 42 CFR 438.228(a), Contractor shall give enrollees reasonable assistance with Contractor's grievance process or with TennCare's appeal process. For example, Contractor shall be prepared to provide enrollees with the telephone number for filing TennCare appeals by phone and with the fax number and address for filing TennCare appeals in writing. Contractor shall also give enrollee's reasonable assistance by providing auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with Teletypewriter/Telephone/Telecommunication Device for the Deaf (TTY/TDD) and interpreter capability.
- (b) In accordance with 42 CFR 438.406(b) and 42 CFR 438.228(a), Contractor shall acknowledge receipt of an enrollee grievance. If enrollee attempts to file a written TennCare appeal by submitting the appeal to Contractor instead of to TennCare, Contractor must submit the request to the TennCare Medical Services Appeals department within one business day for expedited appeal requests and within five business days for standard appeal requests. If enrollee attempts to file a TennCare appeal by phoning Contractor, Contractor should give enrollee the telephone number for filing the appeal directly with TennCare.

6. Decision-Makers.

- (a) In accordance with 42 CFR 438.406(b)(2) and 42 CFR 438.228(a), Contractor shall ensure that decision makers on grievances and decision-makers responsible for rendering a medical review of Contractor's proposed ABD during the Reconsideration stage of the TennCare appeal process were not:
 - (1) Involved in any previous level of review or decision-making; or
 - (2) Subordinates of any individual who was involved in a previous level of review or decision-making.
- (b) Clinical Expertise of Decision-Maker. In accordance with 42 CFR 438.406(b)(2) and 42 CFR 438.228(a), the Contractor's decision-maker shall have appropriate clinical expertise, as determined by TennCare, in treating the enrollee's condition or disease if the decision involves one (1) of the following:
 - (1) the Reconsideration phase of a TennCare appeal involving a denial based on lack of medical necessity;
 - (2) grievance regarding denial of expedited resolution of a request for a TennCare appeal; or
 - (3) grievance or TennCare appeal request involving clinical issues.
- (c) Decision-makers shall take into account all comments, documents, records, and other information submitted during the PA or TennCare appeal process without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

7. Notice of Adverse Benefit Determination (NABD). In accordance with 42 CFR 438.404(b), the Contractor shall issue a NABD to the enrollee, which explains the Adverse Benefit Determination the Contractor has made or intends to make.
 - (a) The NABD shall explain the reasons for the Adverse Benefit Determination, including the right of the enrollee to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's Adverse Benefit Determination. Such information includes, but is not limited to, medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. If the appeal is for a prescription drug that is a controlled substance or has potential for abuse, the Contractor shall also include a copy of the enrollee's State of Tennessee Controlled Substance Monitoring Database (CSMDB) profile with the medical history information.
 - (b) In accordance with 42 CFR 438.404(b), and 438.402(b)-(c), the NABD shall explain the enrollee's right to request a TennCare appeal to contest Contractor's Adverse Benefit Determination.
 - (c) In accordance with 42 CFR 438.404(b), the NABD shall explain the procedures for exercising the enrollee's rights to request a TennCare appeal, and, the circumstances under which the TennCare appeal process can be expedited.
 - (d) In accordance with 42 CFR 438.404(b)(6), the NABD shall explain the enrollee's right to have benefits continue pending the resolution of the TennCare appeal, how to request that benefits be continued, and the circumstances, consistent with State policy, under which the enrollee may be required to pay the costs of continued services.
 - (e) Contractor's NABD templates shall be approved by TennCare and be written in a format and language that, at a minimum, meets applicable notification standards set forth at 42 CFR §438.10 and the notice-content requirements prescribed by 42 CFR §438.404(b).
8. NABD Timing.
 - (a) Timing for NABD following PA denial. If the Adverse Benefit Determination relates to Contractor's denial of a prior authorization request, the Contractor must issue the NABD within 24 hours of receiving a PA request which contains the requisite information for a determination.
 - (b) If the Contractor fails to timely render a PA determination, the Contractor shall issue the NABD to enrollee on the date that the PA timeframe expires. [42 CFR 438.404(c)(5)]
 - (c) Timing of NABD for Denial of Reimbursement. Pursuant to 42 CFR 438.404(c)(2), the Contractor shall issue NABD on the date of determination when the action is a denial enrollee's request for of reimbursement for medications enrollee paid for out-of-pocket.
9. Grievances. The Contractor shall allow enrollees to file grievances with Contractor. If Contractor staff determines that enrollee is actually attempting to file a TennCare appeal instead of Contractor grievance, Contractor staff shall submit the request to the TennCare Medical Services Appeals department within one business day for expedited appeal requests and within five business days for standard appeal requests. If the enrollee attempts to file a TennCare appeal by calling Contractor, Contractor must supply enrollee with the TennCare Medical Services department's telephone number. [42 CFR 438.402(c)(1); 42 CFR 438.408] The Contractor shall allow enrollee-authorized representatives, acting on behalf of the enrollee and with the enrollee's

written consent, to file a grievance or request a TennCare appeal. The enrollee's provider may serve as an authorized representative. [42 CFR 438.402(c)(1)(i) - (ii); 42 CFR 438.408]

10. Timeframes for Filing TennCare Appeal. Enrollee must file a request for a TennCare appeal within sixty (60) calendar days from the date on the Contractor-issued NABD. [42 CFR 438.402(c)(2)(ii)]
11. Process for Filing a Standard or Expedited TennCare Appeal Request
 - (a) Enrollee may request a TennCare appeal either orally or in writing. [42 CFR 438.402(c)(3)(ii)]
 - (b) The enrollee's treating provider, or an enrollee-authorized representative acting on behalf of the enrollee, may file a request for a TennCare appeal either orally or in writing. [42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii)]
 - (c) Unless the TennCare appeal warrants expedited resolution, the oral filing of a request for a TennCare appeal shall be followed by a written, signed request for a TennCare appeal. [42 CFR 438.402(c)(3)(ii)]
 - (d) The filing date of an oral request for a TennCare appeal is the date of the oral request, not the date on which it is ultimately followed by a written, signed request for a TennCare appeal. [42 CFR 438.406(b)(3)]
 - (e) When enrollee files a request for an expedited TennCare appeal, TennCare will issue an On Request Report (ORR). The ORR requires Contractor to determine whether the prospective TennCare appeal warrants expedited or standard resolution and, within one business day of the ORR's issuance, notify TennCare of its decision if the Contractor determines the appeal warrants expedited resolution.
 - (1) If the enrollee's TennCare appeal request warrants expedited resolution, the Contractor shall complete its Reconsideration review and submit its Reconsideration decision to TennCare, along with the other information requested in the ORR, within seventy-two (72) hours of the time that the TennCare appeal request was filed.
 - (2) If the Contractor determines that the TennCare appeal request warrants standard resolution, Contractor shall complete its Reconsideration review and submit its Reconsideration decision to TennCare, along with the other information requested in the ORR, within 14 days of the time that the TennCare appeal request was filed.
 - (3) A benefit under dispute warrants expedited resolution if the Contractor determines that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. [42 CFR 438.410(a)]
 - (4) Information which shall be supplied to TennCare in Contractor's Reconsideration response includes the following:
 - i. complete case file
 - ii. medical records and prescription history pertaining to the benefit under dispute
 - iii. NABD issued to enrollee
 - iv. PA Denial issued to requesting provider

- v. Medical Review substantiating the PA denial
- vi. Reconsideration review upholding or reversing original PA denial

12. Continuation of Benefits

- (a) The Contractor shall continue the enrollee's benefits while the TennCare appeal is in process if all of the following occur:
 - (1) The enrollee files the request for TennCare appeal within sixty (60) calendar days following the date on the NABD; and
 - (2) The contested issue at the TennCare appeal's fair hearing involves a drug that has been previously prescribed (either on an ongoing basis, or with unlimited refills), but which is now subject to prior authorization; and
 - (3) The request for continuation of benefits is filed within ten (10) calendar days of the date on the NABD. [42 CFR 438.420(a); 42 CFR 438.420(b)(1) - (5); 42 CFR 438.402(c)(2)(ii)]
- (b) If, at the enrollee's request, the Contractor continues or reinstates the enrollee's benefits while the TennCare appeal is pending, the benefits shall be continued until one (1) of the following occurs:
 - (1) The enrollee withdraws the request for TennCare appeal; or
 - (2) A TennCare appeal decision adverse to the enrollee is issued. [42 CFR 438.420(c)(1)-(3); 42 CFR 438.408(d)(2)]

13. TennCare Directive.

- (a) The Contractor shall timely comply with any TennCare Directive. Contractor must authorize provision of, or reimbursement for, the benefits which were being contested at the TennCare appeal's fair hearing within seventy-two (72) hours of receiving a TennCare Directive instructing Contractor to do so. For example, if TennCare determines during the TennCare appeal process that the benefits under dispute are medically necessary, TennCare will issue a Directive instructing Contractor to authorize provision of the benefits under dispute. The Directive will instruct Contractor to approve provision of the benefit within seventy-two (72) hours of the Directive's issuance, or sooner if the enrollee's health condition requires. [42 CFR 438.424(a)]
- (b) If, during the Contractor Reconsideration phase of the TennCare appeal process, the Contractor overturns its initial denial of the contested benefit, the Contractor shall authorize provision of the benefit as promptly as the enrollee's health condition requires, but no later than seventy-two (72) hours from the date it receives notice reversing the determination). [42 CFR 438.424(a)]
- (c) Proof of Compliance with TennCare Directive. After authorizing provision of, or reimbursement for the contested benefit, the Contractor shall take measures to ensure that enrollee actually receives the now-authorized benefit. The Contractor must timely provide TennCare with evidence substantiating Contractor's compliance with the TennCare Directive.
- (d) The Contractor shall pay for disputed services received by the enrollee while the TennCare appeal was pending when the Contractor, on Reconsideration,

or the fair hearing officer reverses a decision to deny authorization of the disputed benefits. [42 CFR 438.424(b)]

14. Grievances

- (a) The Contractor shall allow an enrollee to file a grievance with Contractor at any time. [42 CFR 438.402(c)(2)(i)]
- (b) The Contractor shall allow enrollee to file a grievance either orally or in writing. [42 CFR 438.402(c)(3)(i)]
- (c) The Contractor shall resolve each grievance and provide notice, as expeditiously as the enrollee's health condition requires, within ninety (90) calendar days from the day the Contractor receives the grievance. [42 CFR 438.408(a); 42 CFR 438.408(b)(1)]
- (d) The Contractor may extend the timeframe for processing a grievance by up to fourteen (14) calendar days:
 - (1) If the enrollee requests the extension; or
 - (2) If the Contractor shows that there is need for additional information and that the delay is in the enrollee's interest. [42 CFR 438.408(c)(1)(i) - (ii); 438.408(b)(1)]
- (e) If the Contractor extends the timeline for a grievance not at the request of the enrollee, it shall:
 - (1) Make reasonable efforts to give the enrollee prompt oral notice of the delay; and
 - (2) Give the enrollee written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision. [42 CFR 438.408(c)(2)(i) - (ii); 42 CFR 438.408(b)(1)]
- (f) The Contractor shall notify an enrollee of the resolution of a grievance in a format and language that is approved by TennCare and, at a minimum, meets notification standards set forth in 42 CFR 438.10. [42 CFR 438.408(d)(1); 42 CFR 438.10]

15. Grievance and TennCare Appeal-related Recordkeeping Requirements

- (a) The Contractor, and as applicable its subcontractors, shall retain enrollee grievance and TennCare appeal process-related records described in 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.
- (b) The Contractor's record shall include:
 - (1) A general description of the reason for the TennCare appeal request or grievance;
 - (2) The date received;
 - (3) The date of each review or, if applicable, review meeting;
 - (4) Information on how the grievance or TennCare appeal was resolved;
 - (5) The date of resolution; and
 - (6) The name of the enrollee on whose behalf the TennCare appeal request or Grievance was filed. [42 CFR 438.416(b)(1)-(6)]

- (c) The Contractor's record of each grievance or TennCare appeal shall be accurately maintained in a manner accessible to the State and available upon request to CMS. [42 CFR 438.416(c)]

- 16. Contractor Appeals Staff and Training. The Contractor shall have a designated business unit responsible for processing Grievances and TennCare appeal requests (Contractor's Appeals Unit) in accordance with applicable provisions of 42 CFR 438 Subpart F and all TennCare and TennCare Program requirements. The Contractor shall supply the State with the names, responsibilities and contact information of these staff members. The Contractor's Appeals Unit shall include sufficient numbers of appropriately trained and licensed pharmacists, physicians, clinicians, and support staff necessary to timely process and resolve Grievances and TennCare appeal requests in accordance with the terms of this contract. The Grievance and TennCare appeal process requirements are subject to change based on changes in State and federal law, statutes, rules and policies and on the State's interpretation of its obligations under new or existing law. Upon TennCare's request and at no additional cost to the State, the Contractor shall change or update its Grievance and TennCare appeal process in order to establish compliance with any state or federal law, rule, court order, consent decree, or the like.

The Contractor shall provide general and targeted education to Contractor's Appeal Unit staff and to TennCare providers regarding the Grievance and TennCare appeal process. This training shall cover the TennCare provider's rights and obligations concerning the Grievance and TennCare appeal Process, including but not limited to, provider's obligation to timely supply medical or other records necessary for the Grievance and TennCare appeal and requirements concerning submission of requests for expedited PA decisions and requests for expedited TennCare appeal resolution.

- 17. Contractor's Provision of Information about Enrollee Grievance and TennCare Appeal Rights.
 - (a) The Contractor shall inform its contracted Providers and subcontractors about the Grievance and TennCare appeal process and shall inform them of the toll-free number for filing oral Grievances and requests for TennCare appeal with TennCare and for filing oral Grievances with Contractor. See 42 C.F.R. §438.414; 42 C.F.R. §438.10(g)(2)(xi); and
 - (b) The Contractor shall include information about the enrollee's Grievance and TennCare appeal rights in the following materials:
 - (1) Notice of Adverse Benefit Determination;
 - (2) Provider and subcontractor contracts with Contractor;
 - (3) Enrollee Handbook and Provider Manual;
 - (4) Provider training materials; and
 - (5) Contractor's website.
 - (c) The Contractor shall process PA requests as set forth in this contract to avoid Systemic Problems of violations of the law.
 - (d) The Contractor shall process TennCare appeal -related Reconsideration requests as set forth in this contract to avoid Systemic Problems or violations of the law.
 - (d) A failure of twenty percent (20%) or more of appealed cases over a sixty (60) day period regarding any aspect of medical appeals processing pursuant to TennCare rules and regulations and governing appeal procedures may result in liquidated damages as specified in Attachment C.

- (e) The Contractor shall ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures as they become effective. When the Contractor approves a requested service on appeal, the Contractor will assure that the member is notified in writing of such approval.
- (f) The Contractor shall be responsible for eliciting pertinent medical history information from the treating provider(s), as needed, for purposes of making medical necessity determinations. Outreach shall be in the form of phone call, facsimile, and/or email. The Contractor shall provide the State with individualized medical record information from the treating provider(s). The Contractor shall take whatever action necessary to fulfill this responsibility within the required appeal timelines as specified by the State and/or applicable TennCare rules and regulations.
- (g) In addition to providing a reconsideration determination, upon notification of an appeal from TennCare, the Contractor shall produce and deliver to the TennCare all pertinent information regarding that particular prior authorization within the required timeframes.
- (h) The Contractor shall furnish specific telephone numbers for TennCare staff to make contact with the Contractor after Working Hours, and on weekends and holidays in order to assure eligibility and coverage issues can be timely addressed and corrected pursuant to an appeal by a TennCare enrollee. TennCare may request the Contractor's staff to enter a TennCare enrollee's eligibility information and allow processing of pharmacy claims in "after-hours" situations.

A.46.e. TennCare Enrollee-Initiated Prior Authorization (PA) Request

The Contractor shall establish a TennCare enrollee initiated PA process in compliance with TennCare Rules and State statutes that allow TennCare enrollees to request a PA when twenty four (24) hours have elapsed since the claim's denial at the point of service (POS) without a PA request being made by the prescriber. The Contractor shall implement and manage the Enrollee Initiated PA process as follows:

1. The Contractor shall develop an Enrollee Initiated PA Unit for incoming enrollee telephone calls regarding PAs. The Unit shall be fully operational and ready to receive telephone calls on the Go Live date for the TennCare PBM Program.
2. Upon receipt of an enrollee telephone call, the Contractor Call Service Representative (CSR) shall authenticate the caller as a TennCare enrollee or his/her authorized representative and confirm that twenty four (24) hours have elapsed since the provider submitted the claim and received the denial.
3. If the requisite twenty four (24) hours have elapsed, the CSR shall obtain the enrollee's cardholder ID number, confirm the name of the drug the enrollee is requesting for approval, and the name and contact information of the prescriber. The CSR shall also note if the enrollee has previously received this drug.
4. The CSR shall review the information in the reporting system to verify whether the PA process has been initiated by the prescriber. If the prescriber has initiated the process, the CSR shall inform the enrollee of the status of the PA request and ask the enrollee to contact the prescriber for any follow-up inquiries.

5. If the PA process has not been initiated by the prescriber, the CSR shall log a PA request into the Reporting System based on the information provided by the enrollee. The Requester Type shall be logged as "Patient". This shall generate a facsimile to be sent to the prescriber requesting further information to determine if the enrollee meets the necessary criteria for the PA to be granted. The prescriber has three (3) business days from the initial enrollee telephone call to respond to the request for further information.
6. The Contractor shall develop an operational process to identify requests that are still pending after the three (3) business day period has passed, which process shall be approved in writing by TennCare prior to its implementation.
7. At the end of the above process, one (1) of the four (4) following outcomes shall result:
 - (a) The prescriber does not reply to the Contractor within the three (3) business day period. If so, the Contractor shall automatically identify requests that have not received a response, and shall generate letters that inform the enrollee of the outcome. The Contractor shall generate and mail one (1) of the following TennCare approved letters to the enrollee: (1) if the enrollee has not taken the requested drug within the previous forty-five (45) days, a PA Denied Notice shall be sent to that enrollee; (2) if the enrollee has taken the requested drug within the previous forty-five (45) days, a PA Denied – Continuation of Benefits Notice shall be sent to the enrollee.
 - (b) The prescriber changes the drug initially requested to a drug on the TennCare PDL. If so, the Contractor shall log the outcome of the request into the Reporting System. The Contractor shall contact the enrollee to explain this outcome and shall generate and mail the appropriate TennCare approved Prescription Change Notice to the enrollee.
 - (c) The prescriber provides sufficient information to grant a PA. If so, the Contractor shall log the outcome of the request into the Reporting System. The Contractor shall contact the enrollee to explain the outcome and shall generate and mail a TennCare approved PA Granted Notice to the enrollee.
 - (d) The prescriber contacts the Contractor, but the PA request is denied for lack of clinical support. If so, the Contractor shall generate and mail one (1) of the following TennCare approved letters to the enrollee: (i) if the enrollee has not taken the requested drug within the previous forty-five (45) days, a PA Denied Notice shall be sent to the enrollee or (ii) if the enrollee has taken the requested drug within the previous forty-five (45) days, a PA Denied – Continuation of Benefits shall be sent to the enrollee. This shall inform the enrollee of his/her Continuation of Benefits rights through the appeals process.
8. The Contractor shall provide sufficient staff, facilities and technology so that calls to the Enrollee Initiated PA Unit are answered within thirty (30) seconds on at least twenty-seven (27) days per month, and the abandoned calls shall not exceed two percent (2%) on more than three (3) days per month.

A.46.f. PA Program Administration for the TennCare PDL

1. Prescriptions for non-preferred drugs shall require PAs. A PA shall also be required for prescriptions that violate any of a variety of pro-DUR edits and/or are subject to clinical criteria or step therapy.
2. The Contractor shall develop clinical PA review criteria. CMS-approved reference books as well as current medical literature may be used to develop the criteria. The

Contractor shall make all TennCare approved PA review criteria easily understood and widely available to TennCare PBM Program providers through various media, including but not limited to, web based PAs. The Contractor shall also present interim and recommended PA review criteria to the TennCare Pharmacy Advisory Committee prior to final publication and implementation.

3. The Contractor shall develop a plan for administering the TennCare PA program. The plan shall achieve the objective of compliance with the PDL, without unduly disrupting access to care or increasing provider costs, and demonstrate the means by which this shall be accomplished.
4. The Contractor shall provide PA services for prescriptions written for non-preferred drugs or otherwise requiring a PA. PA services shall consist of prescription review by a licensed pharmacist or pharmacy technician to ensure that all predetermined clinically appropriate criteria have been met before the prescription may be dispensed and subsequently reimbursed. The Contractor shall provide readily retrievable documentation for every PA request made, which shall include all information offered by the prescriber, pharmacy, or enrollee, and shall include explanations on what criteria was used to make the final determination, what final determination was made, and by whom. Information and documentation of PA shall be readily retrievable for the purposes of compliance reporting and audits.
5. The Contractor shall have an automated approval process for PAs based on the enrollee's specific drug history, with an emphasis on reduction of transactions and manual interventions.
6. The Contractor shall ensure that all PAs conducted by telephone meet the service and quality standards required by the State in this Contract.

A.47. TennCare Pharmacy Help Desk

- A.47.a. The Contractor shall operate a technical Pharmacy Help Desk with the capability to promptly respond to systems and claims submission inquiries from pharmacies providing services to TennCare enrollees. Pharmacy inquiries arising from eligibility, benefit and DUR edits shall be resolved by the Help Desk. The Help Desk shall also function as an enrollee customer service unit. Technical and enrollee customer service Help Desk hours of operation shall be twenty four (24) hours per day and seven (7) days per week. In no event shall the Help Desk be in an offshore location.
- A.47.b. The State will provide the Contractor with toll-free numbers used by the current TennCare PBM, but the Contractor shall contract, at no additional cost to the State, with an acceptable telephone service carrier to provide the required telephone and facsimile services during the term of this Contract. The Contractor shall be responsible for payment of all such telephone service charges. The Contractor shall operate the toll-free telephone number with sufficient capacity that daily call blockage rates do not exceed point twenty-five percent (0.25%). These toll-free numbers shall be transferred back to the State upon Contract termination. The Contractor shall provide the State with the Help Desk's transfer plan for the toll-free numbers from the existing TennCare PBM contractor to the Contractor no less than sixty (60) days prior to the date the Contractor assumes full responsibility for the pharmacy benefits program. All telecommunication transaction costs are included in the Contractor's compensation set forth in Section C of the Contract, and shall be the sole responsibility of the Contractor.
- A.47.c. The Contractor shall install, operate, monitor and support an automated call distribution system that has capability to provide messaging regarding time to live agent pick up, tele-FAQs and fax-on-demand. The contractor's system shall record all calls in a digital format. The contractor shall allow State staff to monitor calls in real-time and hear specific calls made to the Help Desk if the State provides the date, time or callers number.

- A.47.d. The Contractor shall install, operate, monitor and support a contact management system that has capability to provide the management and on request reporting needs of the State.
- A.47.e. The Contractor shall provide sufficient staff, facilities, and technology to maintain service levels within the Technical Help Desk such that calls are answered within thirty (30) seconds on at least twenty-seven (27) days per month, and the abandoned calls shall not exceed two percent (2%) on more than three (3) days per month.
- A.47.f. All Help Desk inquiries that require a call back shall be returned within one (1) business day of receipt one hundred percent (100%) of the time.
- A.47.g. The Help Desk shall have efficient escalation process with a pharmacist onsite at all times, in order to be able to respond to escalated inquiries within one (1) hour or emergency inquiries immediately.
- A.48. TennCare Program Pharmacy Network Overview
- A.48.a. The Contractor shall establish and maintain a statewide TennCare Program pharmacy provider network (TennCare Provider Network) of Ambulatory, 340B, Specialty, and Long Term Care (LTC) pharmacies, along with Physician Dispensaries. The TennCare Network shall be adequate to provide pharmaceutical services and pharmacy location sites that are available and accessible in accordance with the TennCare provider network requirements established by TennCare. Other than those addressed in this Contract, the Contractor shall not collect any additional fees, rebates, premiums or revenue from processing TennCare claims.
- A.48.b. TennCare MTM Pilot Program. The Contractor shall, upon request from the State via contract amendment, establish, maintain and administer a TennCare MTM Pilot Program in accordance with T.C.A. § 71-5-149, the TennCare Rules, and all applicable State and federal statutes and regulations. The amendment implementing the TennCare MTM Pilot Program shall set forth the specifics of the program, including but not limited to, identifying eligible providers and TennCare enrollees, required documentation, reporting and measurement requirements, data exchange information, and Contractor reimbursement tiers and parameters.
- A.49. TennCare Program Provider Network Requirements
- A.49.a. Access to TennCare Services. The Contractor shall maintain a network of pharmacy providers with a sufficient number of pharmacies to provide for TennCare enrollees within each geographical location in the state so travel times and distances do not exceed the allotted standard for a particular location as established in Contract Section A.49.b. The Contractor shall consider the following:
1. The anticipated need to have a prescription filled outside the service area;
 2. The expected utilization of services, taking into consideration the pharmaceutical needs of specific TennCare populations served by the Contractor;
 3. The numbers and types (in terms of training, experience, and specialization) of pharmacies required to provide the contracted TennCare services; and
 4. The geographic location of pharmacy providers and TennCare enrollees, considering distance, travel time, the means of transportation ordinarily used by TennCare enrollees, and whether the location provides physical access for TennCare enrollees with disabilities.

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

enrollees. The Contractor shall make services available twenty four (24) hours a day, seven (7) days a week, when medically necessary.

- A.49.b TennCare Network Access. The Contractor shall maintain under contract a network of pharmacy providers to provide TennCare covered services such that in:
- i. Urban areas transport access is at least three (3) miles travel distance and at least fifteen (15) minutes travel time as measured by the GeoNetworks® Accessibility Overview Analysis or such other software program as the State may specify;
 - ii. Suburban areas transport access is at least ten (10) miles travel distance and at least twenty (20) minutes travel time as measured by the GeoNetworks® Accessibility Overview Analysis or such other software program as the State may specify; and
 - iii. Rural/Frontier areas transport access is at least twenty-five (25) miles travel distance and at least thirty (30) minutes travel time as measured by the GeoNetworks® Accessibility Overview Analysis, or such other software program as the State may specify.
 - iv. Exceptions shall be justified and documented to the State on the basis of community standards. When requested by the State, the Contractor shall make arrangements to provide pharmacy services to enrollees residing in locations where a suitable network provider is not available.
- A.49.c. TennCare Monthly Provider Enrollment File. The Contractor shall submit a monthly Provider Enrollment File that includes information on all providers of TennCare pharmacy services. The Contractor shall submit this report in the format agreed to by the State. The Contractor shall submit this report by the 5th day of each month, or as otherwise requested by the State. Each monthly Provider Enrollment File shall include information on all providers of TennCare pharmacy services and shall provide a complete replacement for any previous Provider Enrollment File submission. Any changes in a provider's contract status from the previous submission shall be indicated in the file generated in the month the change became effective and shall be submitted in the next monthly file.
- A.49.d. TennCare Provider Directory. In addition to the requirements set forth in Section A. 8, the Contractor shall comply with the following requirements:
1. The Contractor shall be required to produce a provider directory that shall be made available in a machine readable file and format that is located on the Contractor's website in a prominent location. Should the Contractor receive a request for a hardcopy of the provider directory, the Contractor shall provide the hardcopy free of charge to the individual within five (5) days of the person's request. All provider directories shall be approved by the State prior to the Contractor's distribution. The Contractor shall provide a data file that shall include current pharmacy provider name, NPI, address(es), telephone numbers, fax numbers, email address and hours of operation in the format prescribed by the State. In addition, the provider information used to populate the provider directory shall be submitted as a TXT file or such format as otherwise approved by the State and be produced using the same extract process as the actual provider directory. On a weekly basis, the Contractor shall also be responsible for updating the pharmacy provider information in the provider directory.
 2. The Contractor shall require all network providers to have online access to the Contractor's website, and shall require current email addresses from each network provider.
- A.49.e. TennCare Pharmacy Notices. The Contractor shall assure that contracted pharmacies comply with TennCare notice requirements which include, but are not limited to distribution of member notices from pharmacist to enrollee upon non-dispensing of a prescription for which

PA is required. The Contractor shall utilize feedback from the State, other state agencies, and enrollees, to perform additional training to pharmacies regarding notice obligations.

A.49.f. TennCare Pharmacy Audit. The Contractor shall establish and maintain a TennCare approved Program Integrity process. The process shall detect and prevent errors, fraud or abusive pharmacy utilization by enrollees, pharmacies or prescribers. The Contractor shall also review children's prescriptions at POS to screen for possible fraudulent attempts by adult recipients to obtain prescriptions for themselves. Pharmacies with aberrant claims or trends shall be contacted by the Contractor's staff to gain an acceptable explanation for the finding or to submit a corrected claim. The Contractor shall develop a trend or log of aberrations that shall be shared with the State. Each quarter the Contractor shall summarize findings from the reports and meet with the State to address program revisions. Revisions to the desk audit reports and review process shall be provided at no cost to the State. Program Integrity activities shall be summarized and reported to the State as directed in writing by TennCare. This section in no way limits or circumscribes, or supplants the requirements established in Sections A.23, A.24, and A.25 of this Contract.

1. The State shall request that the Contractor initiate a field audit when desk audits consistently identify aberrations that cannot be explained by other means or upon requests from legal authorities or regulatory agencies. The objective of the field audit shall include financial recovery, and elimination of the aberrant practice. The Contractor shall have the qualified staff available to conduct field audits or have an agreement with a vendor acceptable to the State within ninety (90) days of the TennCare Program Go Live date. The Contractor shall conduct ten (10) field audits per quarter.
2. Verification of Benefits (VOB) Letters. When unsigned signature logs are found in desk audit results, recipients shall be sent a letter requesting their reply to confirm whether they received the prescriptions not signed for.
 - a. Each mailing shall include a double-sided document including the letter on the front page, with the claim detail and signature line on the back, as well as a postage paid envelope for the recipient to use for the return mailing. The letters must be preapproved by the State.
 - b. The State shall be responsible for postage related to the mailing of these letters, as well as the return postage.
 - c. VOB responses shall be followed up on by the Contractor's audit unit and the Contractor shall provide the State with a quarterly report on the findings from the responses.
 - d. Upon request by the State for a targeted mailing, Contractor shall also send up to five hundred (500) letters to providers or recipients requesting their reply to confirm whether they prescribed or received the prescriptions not signed for, with results from the mailing to be reported to the State within thirty (30) days of request.

A.49.g. The CONTRACTOR shall ensure that payments are not issued under this Contract for an item or service in accordance with the following:

1. To providers that have not obtained a Tennessee Medicaid provider number or for which disclosure requirements, as applicable, have not been obtained in accordance with 42 CFR 455.100 through 106, this Contract, and TennCare policies and procedures.

A.50. TennCare Reporting Requirements

The Contractor shall submit timely, accurate and complete reports to the State as required in this Contract. Reports must meet TennCare content, format and method of delivery requirements. The Contractor shall provide all reports in accordance with the time frames set forth in Attachment D. All reports, analyses, and/or publications developed under this Contract shall be the property of the State. The State reserves the right to add additional reports, change reporting requirements and request On Request Reports (ORRs) as deemed necessary. All reporting shall be delivered through a web-based report library that can be imported to Microsoft Excel, or formatted as tab- or comma-delimited text files, or in such other format or method as directed by the State.

A.50.a. TennCare Management Reports

The Contractor shall provide TennCare with State approved electronic utilization and financial management reports, including but not limited to the reports identified on Attachment D of this Contract. The Reports shall be provided to the State in a format agreed upon by the parties using templates provided to the Contractor in a Control Memorandum.

A.50.b. Additional TennCare Capabilities and Custom Reports. In addition to standard management reports, the Contractor shall provide the following additional capabilities and custom reports as indicated below, or as modified by the State in writing, in a format agreed to by the State.

1. TennCare Clinical Initiative Reports. As clinical programs are implemented, the Contractor's staff shall coordinate with the State to define additional reports to gauge the effectiveness of various clinical initiatives, including movement of market share within given therapeutic categories of the TennCare PDL. The criteria and format for clinical initiative reporting shall be mutually agreed upon by the State and the Contractor. The Contractor's utilization management reporting package shall be customizable to meet TennCare program analysis needs, including but not limited to preferred product indicators or PDL indicators being available for all claims level reports.
2. TennCare On Request Reports (ORRs) and Ad Hoc Reports. The Contractor shall be able to provide, at no extra cost to the State, ORRs and Ad Hoc Reports that shall assist in managing the pharmacy benefit for TennCare members. ORRs and Ad Hoc Reports shall be provided in a format agreed to by the State and on a reasonable timetable.
3. TennCare Decision Support Tools. The Contractor shall provide TennCare staff with access to the Contractor's Data Warehouse allowing the State to retrieve claims data including raw paid, rejected and reversed claims, provider data (both pharmacies and prescribers), drug data (inactive and active drugs, with historical pricing), enrollee data (all enrollees received on 834 files, including active and inactive enrollees), and medical data (ICD-10 and procedure codes) along with a user interface that shall allow user defined queries to address managerial concerns that would normally be requested in an ORR. The Data Warehouse that is accessed by the user interface provided by Contractor shall include all fields used in adjudication, and all fields provided to Contractor by the State. Contractor shall provide to the State a data dictionary at Go-Live and upon changes thereafter, which describes each field available in Contractor's Data Warehouse, along with all possible values and a definition of each value in each available field. The data dictionary shall be approved by TennCare prior to use.

Access to the Contractor's Data Warehouse shall not diminish the Contractor's responsibility for responding to requests for ORRs. Contractor shall be responsible to offer assistance to State staff that are using Contractor's Data Warehouse as needed, including both pharmacy staff and other departmental staff's users.

4. TennCare Staff Online and Remote Access. The Contractor shall provide the State staff and their designees, including but not limited to TennCare MCOs and other

State entities, as allowed by law, individual access to the Contractor's TennCare POS claims system, prior authorization system, decision support system and other information systems as necessary via an online, real time connection at no additional cost. Contractor shall not impose limits on the number of licenses made available to State staff, designees, State and federal auditors, MCOs and other State entities.

5. TennCare Emergency Supply Aggregate Reports. The Contractor shall provide the State with monthly emergency supply claims reports listing the enrollee information, drug information, quantity and day's supply, pharmacy and prescriber information, along with the reason the original claim was rejected (Non-PDL, Clinical Criteria required, etc.). The Contractor shall also provide semi-annual aggregate reports that list the top 100 pharmacies entering emergency supplies. The emergency supply reports shall be delivered to the State in electronic format via web-based report library, as required by the State.
6. TennCare Help Desk and Prior Authorization Call Center Activity Reports. The Contractor shall produce reports on usage of the Help Desk and Prior Authorization Call Center services, including numbers of inquiries, types of inquiries, and timeliness of responses. Help Desk Activity Reports shall be reported to the State as a split skill daily interval report. Prior Authorization Call Center Activity Reports shall be reviewed by the Contractor daily and report to the State immediately when abnormal results occur. If there are no urgent issues from the Prior Authorization Call Center Activity Report, these reports are to be reported to the State during quarterly clinical meetings and monthly Call Center conference calls.
7. TennCare Help Desk Reporting. The Help Desk Call Center reporting shall be reviewed by the Contractor daily and reported to the State when there is a deviation of more than ten percent (10%) from the service level requirements set forth herein over a period of three (3) days occurs. This report shall, at a minimum, include the following:
 - (a) Total hours of daily call center access provided, and any downtime experienced;
 - (b) Call abandonment rate, and average abandonment time by day;
 - (c) Average answer speed in seconds by day;
 - (d) Average/Automatic Call Distribution time of calls handled by day;
 - (e) Average wait time per caller;
 - (f) Number of calls answered daily, and
 - (g) Number of calls transferred to the State.
8. TennCare Prior Authorization (PA) Call Center Reporting. Prior Authorization Call Center reporting shall be reviewed by the Contractor daily and reported to the State when PA processing requirements are not met, and, at a minimum, shall include the following:
 - (a) Total hours of daily call center access provided, and any downtime experienced;
 - (b) Call abandonment rate, and average abandonment time by day;
 - (c) Average answer speed in seconds by day;
 - (d) TennCare Comprehensive Requests Report. Comprehensive report listing the type and disposition of all requests handled during the month. Report should provide approval rates by drug and therapeutic class;
 - (e) TennCare Request Volume Report. Request volume by prescriber and pharmacy, with indication of the key types of requests being received, including drug names and categories;

- (f) Average ACD time of calls handled by day;
- (g) Total number of intervention requests received by day;
- (h) Total number of PA requests processed by day;
- (i) Total number of PA requests approved by day;
- (j) Total number of PA requests denied by day;
- (k) Total number of intervention requests received by facsimile by day;
- (l) Total number of intervention requests received by U.S. Mail by day, and
- (m) Total number and types of complaints received from TennCare enrollees regarding any difficulties receiving pharmacy services under the TennCare Pharmacy Program by day.

- 9. Top 500 Controlled Substance Prescribers Report Card. Twice yearly the Contractor will report on the Top 500 prescribers of controlled substance prescriptions which includes, but is not limited to, number of each type of opioid claim, total morphine equivalent daily dosage, number of denied claims for benzodiazepines, methadone and carisoprodol, claims, enrollees, enrollee demographic information such as MCO, and prescriber demographics, along with supervising physician information if the prescriber is a mid-level practitioner.
- 10. Legislative Controlled Substances Report. Annual controlled substance report required by T.C.A § 53-10-309.
- 11. TennCare Monthly Benefit Limit Report. Monthly benefit limit report summarizing the number of recipients and claims encountering prescription limits, number of recipients and claims filled from Auto-Exemption list and number of recipients and claims filled through the Attestation process, and semi-annual summaries of the top prescribers utilizing the Attestation process.

A.50.c. TennCare Member Satisfaction Reports. If requested by TennCare, the Contractor shall conduct periodic surveys of member satisfaction with its services.

- 1. The surveys shall include content on perceived problems in the quality, availability, and accessibility of care.
- 2. As a result of the surveys, the Contractor shall:
 - (a) Identify and investigate sources of TennCare member dissatisfaction;
 - (b) Outline action steps to follow up on the findings; and
 - (c) Inform providers of assessment results.
- 3. The Contractor re-evaluates the effects of the above activities.

A.50.d. TennCare Provider Satisfaction Reports. If requested by TennCare, the Contractor shall conduct periodic surveys of provider satisfaction.

A.50.e. TennCare Monthly PDL Compliance Reports. The Contractor shall monitor compliance by prescribers and pharmacists with the TennCare PDL and report that information to the State monthly, quarterly, and semiannually, and provide suggestions for improving PDL compliance. The Contractor shall produce the monthly PDL compliance reports listed below, in a format agreed to by the State.

1. Monthly Cost Savings/Avoidance Report that includes: utilization shifts by drug and drug class; cost savings by pharmacy paid amount and by net cost resulting from changes in prescribing, by drug and drug class; compliance with TennCare PDL drug classes by prescribers; expenditure per claim comparison (monthly/quarterly/yearly);
2. Quarterly evaluation of the effectiveness of the TennCare PDL and Prior Authorization programs, including recommendations for changes to TennCare PDL drugs, the criteria for review and approval of drugs, and protocols and procedures;
3. Monthly Supplemental Rebate Negotiations Status Report underway and/or completed, the status of negotiation outcomes and the product-specific financial impact of the supplemental rebates on the TennCare PDL;
4. Report on Total Estimated and Projected Future Savings from the TennCare PDL and Prior Authorization programs (monthly for the initial twelve (12) months of this contract and quarterly thereafter) when requested by the State, and
5. Quarterly reports, to be presented to the State by Contractor's Provider Educator staff, demonstrating the nature and extent of educational interventions to outlier prescribers and pharmacists and the clinical and financial outcomes of those interventions.

A. 50.f. TennCare Claims Analysis Reports. The Contractor shall produce the TennCare Claims Analysis reports identified below. Daily reports shall be produced, reviewed and delivered daily Monday through Friday by 3:00pm CT. Monthly reports shall be produced and reviewed monthly by ten (10) business days after end of month.

1. TennCare Ingredient Cost/Prescription Report. This daily report shall identify claims with a total cost that exceeds Two Thousand Dollars (\$2,000.00) at retail. Claims in this report shall be flagged if the product is considered by the State to be a specialty drug. The claims must be reviewed by Contractor's clinical pharmacists on a daily basis for reasonableness, and reported to the State when/if abnormal results occur. Report to be used to identify incorrect claims submission, for identification medications for steerage to specialty vendors and for identification opportunities to suggest utilization management edits or benefit design changes.
2. TennCare Override Report. Daily claims paid with unique adjudication rule reporting, as defined by the State, as requested by the State.
3. TennCare Enrollee Potential Lock-in Review Report. The report shall screen for inappropriate, duplicate or conflicting pharmacotherapy; screen for potential fraud or drug diversion; and identify patients for referral to pain management or substance abuse services. The report shall identify enrollees for pharmacy lock-in initiative. The State shall define the report base on the number of prescribers, pharmacies, percentage controlled substance dose exceeding the Maximum Daily Dose, and other indications of potential abuse including buprenorphine utilization for opioid detoxification. The report shall be produced and reviewed monthly within ten (10) business days after end of month.
4. TennCare Pharmacy Dispense as Written (DAW) Code Submission. The report shall identify the top twenty (20) pharmacies and the top twenty (20) prescribers associated with claims submitted as DAW-1. The report shall be produced and reviewed monthly by ten (10) business days after end of month.
5. TennCare Pharmacy Claim Reversals Report. The report shall identify pharmacies for which claim reversals may have manipulated payment by excessive reversals or failure to issue credits. This report identifies pharmacies whose reversals total greater than three (3) percent or less than one percent (1%) of the total submitted

prescription claims in a period. The report shall be produced and reviewed monthly by ten (10) business days after end of month.

6. **TennCare Generic Utilization Report.** A report that shall identify pharmacies which are not maximizing generic switch opportunities and cost savings; screen for potential site audit for facility inspection or record keeping; and identify optimization of generic dispensing opportunities. Generic efficiency shall mean the number of generic prescriptions dispensed divided by the number of generic prescriptions plus the number of multi-source brand prescriptions. The calculation shall be based on a minimum of two hundred and fifty (250) non-specialty drug claims per quarter and less than sixty percent (60%) generic utilization. The report shall be produced and reviewed monthly within ten (10) business days after the end of the respective month.
7. **TennCare Pharmacy Submission of Package Size versus Days Supply.** The report shall identify claim manipulation by pharmacies by screening for invalid correlation between the quantity and days' supply submitted (i.e., eye drops, ear drops, miscellaneous topical preparations). Report shall identify inconsistencies between package size and days' supply for the following: eye, ear, nasal preparations, or other miscellaneous topical preparations. The report shall be produced and reviewed monthly by ten (10) business days after end of month
8. **TennCare Pharmacy Time of Claims Submission.** The report shall identify controlled substance prescription claims submitted between 10:00 p.m. and 6:00 a.m. and identify the number and type of prescriptions filled between this time period to evaluate for claim fraud, controlled substance abuse, and drug diversion.
9. **Pharmacy claims denied for Reject Code 70—**The report shall identify all claims each week denied for "NDC Not Covered", and the reason for the denial to ensure that drugs that should be paid for are not rejected for this reason.

A.51. Contractor Communication Specific to TennCare PBM Program Enrollees. In addition to the communications requirements set forth in Section A.8, the Contractor shall comply with the following provisions:

A.51.a. TennCare Enrollee Notices. The Contractor shall be required to only use enrollee notice templates provided by the State to send individualized notices to enrollees. If the Contractor sends an incorrect notice to an enrollee, the Contractor shall submit a timely corrected notice of adverse benefit determination to the State for review and approval prior to issuance of the corrected notice to the enrollee.

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

1. Notification of prescription limits being met
2. Notification that a Prior Authorization request has been denied, which may or may not include a provision for continuation of benefits
3. Outcomes of a member initiated prior authorization request, which may include:
 - (a) Prescription change;
 - (b) PA granted; or
 - (c) PA denied.
4. Notification of drug not covered

5. Notification of blocked prescriber
 6. Notification of pharmacy lock-in and/or notification of escalation or assignment to PA Status
 7. Response to prescriber on outcome of prior authorization request. This may be completed by utilizing facsimile technology.
- A.51.b. The Contractor shall clearly document and communicate the reasons for each denial of prior authorization request in a manner sufficient for the provider and member to understand the denial and decide about requesting reconsideration of or appealing the decision.
- A.51.c. The Contractor shall comply with all member notice provisions in TennCare Rules, and all court orders and consent decrees governing the appeal procedures as they become effective.
- A.51.d. Notices shall be mailed Monday through Saturday of each week, excluding Sundays. The previous day's claims and/or Prior Authorization requests shall be mailed the following day. Monday mailings shall include letters based on claims denied on Saturday and Sunday. The Contractor shall provide the State with a web-based system to search and view individual notices that have been sent. The Contractor shall have approval to subcontract the notice process as defined herein with the requisite approval from the State, but in no event shall off shore vendors be utilized. The direct postage cost for recipient prescription limit denial letters, prior authorization letters, non-covered drug letters, blocked prescriber letters, and lock in letters shall be a pass through item.
- A.51.e. TennCare DCS Eligibility Record File. The State shall provide the Contractor with an eligibility record file containing indicators identifying recipients in the Department of Children's Services (DCS). Updates to this file will be provided on a weekly basis. The Contractor shall produce copies of any recipient denial notices generated over the previous week and forward the notices (via secure electronic file transmission) to DCS.
- A.51.f. TennCare Prescription Limit Letters. The Contractor shall generate, and mail letters to recipients regarding claims denied for the Script Limit edit. The extract shall be inclusive of claims that have received the initial denial for exceeding the limit of five (5) scripts per month and/or two (2) brand name scripts per month. Recipients shall receive a maximum of two (2) letters monthly, related to the maximum of five (5) scripts monthly and/or the maximum of two (2) brand scripts monthly. If two (2) letters are generated in an extract for the same mailing, they shall be mailed as two (2) separate pieces of mail. The State shall draft each of the two (2) possible recipient Script Limit denial letters for submission to the Contractor. Recipient letters shall be generated on TennCare letterhead. The return address on recipient letter mailing envelopes shall be identical to that on mailing envelopes for recipient ID cards:

TennCare Pharmacy Program
c/o the Contractor

- A.52. TennCare Program Performance Guarantee.
- Pursuant to Contract Section A.39, the Performance Metrics listed below have been selected by the State as the initial Performance Metrics to be used for the TennCare PBM Program, to take effect following TennCare Go Live, pursuant to a Control Directive to be issued by the State. Using these Performance Metrics, the following illustration shows hypothetical results for Contractor's services for one (1) month, including the Performance Metrics Pass/Fail Score, determination of the percentage of the TennCare Administrative Fee that will not be paid to Contractor for this month, and the total amount of the TennCare Administrative Fee that will be paid to Contractor for this month. The Pass/Fail Scores and all figures shown below are for illustration purposes only and shall not be deemed to revise or amend any provisions of this Contract.

Performance Metric	Pass/Fail Criteria	Pass/Fail Score
1. PA Processing	If any of the PA Processing metrics listed below are not met, the Pass/Fail Score shall be a Fail for the month.	Pass
1.a Complete PA requests	Attachment G, Table 1, Item 1	(Pass)
1.b Pended PAs	Attachment G, Table 1, Item 2	(Pass)
1.c PA Attestations	Attachment G, Table 1, Item 3	(Pass)
2. Call Center	If either of the Call Center metrics below are not met, the Pass/Fail Score shall be a Fail for the month.	Pass
2.a Call Response Time	Attachment G, Table 1, Item 4	(Pass)
2.b Call Abandonment Rate	Attachment G, Table 1, Item 5	(Pass)
3. Reporting	If any of the metrics below are not met, the Pass/Fail Score shall be a Fail for the month.	Fail
3.a Required Reports	Attachment G, Table 1, Item 6	(Fail)
3.b Contractor Data Warehouse	Attachment G, Table 1, Item 7	(Pass)
3.c Ad Hoc Reports and ORR Reports	Attachment G, Table 1, Item 8	(Pass)
4. Adjudication System Performance	If either of the Adjudication System metrics listed below are not met, the Pass/Fail Score shall be a Fail for the month.	Pass
4.a System Errors	Attachment G, Table 1, Item 9	(Pass)
4.b Hours of Operation	Attachment G, Table 1, Item 10	(Pass)
5. Pharmacy Network		Pass

	If any of the Pharmacy Network metrics listed below are not met, the Pass/Fail Score shall be a Fail for the month	
5.a Provider Agreements	Attachment G, Table 1, Item 11	(Pass)
5.b Provider Enrollment	Attachment G, Table 1, Item 12	(Pass)
5.c Pharmacy Panel Assignment	Attachment G, Table 1, Item 13	(Pass)

Performance Guarantee Payment Calculation – Per Contract Section C.3, up to twenty percent (20%) of Contractor’s total monthly TennCare Administrative Fee shall, as applicable, be reduced by the percentage that reflects Contractor’s Performance Metrics Pass/Fail Score for the month. The total amount of TennCare Administrative Fee to be paid to Contractor for this month in the above illustration is based on Contractor having passed four (4) of the metrics and failed one (1) metric and is determined according to the following calculation:

Step 1. Determination of percentage of monthly TennCare Administrative Fee that will not be paid to Contractor for this month:

Number of Performance Metrics failed	1	2	3	4	5
Percentage deducted from monthly TennCare Administrative Fee Payment	5%	10%	15%	20%	20%

Step 2. Determination of amount of TennCare Administrative Fee that will be paid to Contractor for this month:

Full amount of monthly TennCare Administrative Fee - 5% = total amount of monthly TennCare Administrative Fee to be paid to Contractor

A.53. TennCare Program PBM Risk Sharing Module (Risk Sharing Module)

A.53.a. Prior to the implementation of the Risk Sharing Module described herein, if the Contractor is not already qualified to operate as a partial risk-bearing entity for PBM services, with savings and losses to be shared with the State, it shall qualify to operate as a risk bearing entity for this purpose. The Contractor shall notify the State of any person or corporation that has a five percent (5%) or more ownership or controlling interest in the Contractor, and such person or corporation shall submit financial statements to TennCare upon request. The Contractor shall meet all licensure requirements set forth in Title 56 of the Tennessee Code Annotated to operate as a risk bearing entity, and, unless Contractor is a Federally Qualified HMO, it shall provide assurances satisfactory to the State to show that the Contractor has made provisions against the risk of insolvency that are adequate to ensure that its TennCare enrollees shall not be liable for the debts of the Contractor if it becomes insolvent.

A.53.b. The State will, in its sole discretion and if it determines the Risk Sharing Module is in the best interest of the TennCare PBM Program, implement the Risk Sharing Module at a time to be determined by the State following the TennCare Program Go Live date, depending on the level of uncertainty in the Medicaid environment. It is anticipated that the earliest the Risk

Sharing Module will be implemented is one (1) year after the TennCare Program Go Live date. The State shall give the Contractor a minimum of three (3) months advance written notice of its intent to implement the Risk Sharing Module to allow sufficient time for consultation between TennCare and the Contractor to develop the specifics of the Risk Sharing Module. All information concerning implementation and operation of the Risk Sharing Module shall be incorporated into this Contract using the Control Memorandum process outlined in Section A.5. The Control Directive Implementing the Risk Sharing Module shall specify all pertinent information concerning the Risk Sharing Module, including but not limited to, description(s) of the disease state(s) to be included, historic service expenditure baseline amount, data gathering requirements, and reporting and measuring responsibilities.

Risk Sharing Module calculations are influenced by two (2) variables: (a) annual service expenditures for specified medical conditions(s), and (b) the percentage risk level chosen by the Contractor in its RFP Cost Proposal Bid response related to this Contract. The Contractor's risk level percentage will determine maximum Gain/Loss payment, and is set forth in Section C.3. To calculate the Risk Sharing Module Gain/Loss amount, the following calculation will be used:

$$\begin{aligned} & \text{Performance Year Spend} \\ - & \text{Baseline Year Spend} \\ = & \text{Total Risk Sharing Gain/Loss Amount} \\ + & \text{Applicable Performance Quality Metric Payment} \\ = & \text{Final Gain/Loss Amount} \end{aligned}$$

Contract Attachment H contains a Risk Sharing Module illustration and a table showing Final Gain/Loss Amount calculations for five (5) hypothetical scenarios based on the hypothetical quality metric chosen for this illustration. All information, scenarios and figures shown in Attachment H are for illustration purposes only and shall not be deemed to revise or amend any provisions of this Contract.

A.54. TennCare Program Performance Improvement Projects (PIPs)

The Contractor shall conduct performance improvement projects (PIPs) in accordance with federal law and CMS protocols, including but not limited to 42 C.F.R. § 438.330. All PIPs must be approved by TennCare prior to implementation. TennCare reserves the right to provide further direction and guidance on PIPs via the Control Memorandum Process outlined in Contract Section A.5.

CoverRx Pharmacy Services

A.55. CoverRx Services Implementation and Requirements Plan

A.55.a. CoverRx Services Requirements Overview. The Contractor shall provide administrative services for the CoverRx Program in compliance with all CoverRx requirements set forth in this Contract. The Contractor's services shall include, but are not limited to the following:

1. CoverRx Plan Management System. The Contractor shall develop, implement, maintain and operate a CoverRx plan management system (CoverRx System) capable of satisfactorily meeting all requirements and performing all functions set forth herein. The Contractor shall work with TennCare to ensure that the CoverRx System satisfies all functional and informational requirements of the CoverRx Program. The CoverRx System shall be thoroughly tested and accepted by the State pursuant to the requirements set forth below prior to CoverRx Go-Live. The Contractor's CoverRx System shall, at a minimum, provide the following functions and services:

- (a) CoverRx eligibility management, member enrollment, and production and mailing of Participant Communication Materials defined below;
- (b) Data interface with the TennCare 834 File to perform a daily comparison of TennCare enrollees to the CoverRx enrollees shown in the Contractor's CoverRx membership database and generate disenrollment file reports for Contractor's CoverRx operations staff to disenroll those CoverRx members who are also enrolled in the TennCare Program;
- (c) POS claim adjudication configuration and management, including all necessary hardware. POS claims adjudication services shall be provided on a 24-hours-a-day, 7-days-a-week, 365-days-a-year basis, except for preapproved POS system maintenance or other CoverRx System down time;
- (d) CoverRx check writing configuration and management functions shall remain separate from that of any other PBM Program operated by the Contractor, and shall include a separate CoverRx bank account, all necessary hardware and weekly check writing services, pharmacy provider payment and remittance advice (RA) distribution;
- (e) Rebate contracting and administration: The Contractor shall develop, implement and operate a system acceptable to the State to handle drug rebate administration for the CoverRx Program, including rebates for diabetic supplies, insulins, albuterol inhalant products, and any other products the State may, in its sole discretion, designate in writing. The Contractor shall negotiate contracts for CoverRx rebates and submit all manufacturer proposals and contracts to the State for review and approval. The Contractor shall submit rebate invoicing, payment posting, and dispute resolution processes as set forth in Section A.57.j. CoverRx Rebate Administration;
- (f) All data interfaces required to support CoverRx POS claim adjudication;
- (g) Online tool(s) for use in creating management and operational reports that are capable of providing ad hoc analytical services and reports.
- (h) Account management services and support, and
- (i) Access to all information in the CoverRx System by State designated staff and contractors.

2. CoverRx Enrollee Membership. The Contractor shall be responsible for all aspects of member enrollment and re-enrollment, including the management of the enrollment process, and the production and distribution of enrollment documents, including, but not limited to, enrollment letters, benefit identification cards and such other enrollment documents as the State may designate in writing from time to time (collectively referred to herein as the "Participant Communication Materials"). The Contractor shall manage membership for the Tennessee CoverRx program including, but not limited to, eligibility determination, enrollment processing, and the distribution of enrollment materials.

- (a) The Contractor's CoverRx System shall handle eligibility determination and enrollment in compliance with the State's CoverRx eligibility criteria, and shall have the capability to:
 - (1) Assess whether or not an individual applicant meets the State's eligibility criteria;
 - (2) Enroll each eligible individual subject to the State's criteria;

- (3) Make a determination of eligibility within five (5) business days of receipt of a completed application for no less than ninety-five percent (95%) of new participants. A completed application is defined as one in which the applicant has provided all required data and supporting documentation;
 - (4) Issue participant enrollment cards, and such other Participant Communication Materials as the State may direct, within seven (7) business days of determining eligibility. These Participant Communication Materials shall be distributed to no less than ninety-five percent (95%) of new participants within the required timeframe;
 - (5) Track and provide monthly reports, in a form acceptable to the State, regarding intake of applications, distribution of Participant Communication Materials and overall compliance with the CoverRx requirements of this Contract.
 - (6) Thirty (30) days prior to each participant's anniversary date, annually verify participant eligibility for no less than ninety-five percent (95%) of participants;
 - (7) Track verification of participant eligibility and provide a monthly report, in a form acceptable to the State, regarding its compliance; and
 - (8) Handle any changes to the CoverRx program that the State, in its sole discretion, deems necessary and in the best interest of the program.
 - (b) The Contractor shall accept CoverRx member enrollment by, mail, facsimile, and via the internet. Contractor's CoverRx System shall provide an interactive website for direct application through the website and shall provide re-enrollment reminder messages via text messaging. The Contractor's enrollment validation process shall be limited to the proper completion of the enrollment form based solely on information provided by a CoverRx applicant. Other than to verify that an applicant is not attempting to simultaneously participate in both TennCare and CoverRx, the Contractor may accept the contents of an applicant's CoverRx enrollment form without independent verification of the information contained therein. Participation in both TennCare and CoverRx at the same time is prohibited by the State. However, if an applicant meets all CoverRx eligibility requirements when his/her TennCare eligibility is terminated, the applicant may, at the State's discretion, be immediately enrolled in the CoverRx Program (CoverRx Auto-Enrollment). Upon request from the State, Contractor shall establish an interface between the TennCare POS System and the CoverRx System to allow CoverRx Auto Enrollment.
 - (c) At the State's sole discretion, TennCare may at any time choose to reduce the number of CoverRx participants or the scope of the CoverRx Program enrollment services, including, without limitation, discontinuing internet enrollments.
3. CoverRx Reports. The Contractor's CoverRx System shall support the development and production of operational, ORR and ad hoc reports for the enrollment management process. The Contractor shall submit Management Reports in a mutually agreeable electronic format (such as, but not limited to, MSWord or MSEXcel), of the type, at the frequency, and containing the detail described in Contract Attachment E, or as otherwise directed by the State, in writing.

4. **CoverRx Claims Adjudication.** The Contractor's CoverRx System shall include an end-to-end claim adjudication system capable of adjudicating claims at point-of-sale (POS) and process all electronic retail and mail order pharmacy claims incurred during the term of the Contract in accordance with the CoverRx Covered Drug List (CDL) and CoverRx program requirements. The Contractor shall provide efficient and timely processing and approval of participant's claims and submission of those claims to the State. The State retains all discretion for determining whether claims are paid, denied in part, or denied in whole. In the event the State receives inquiries concerning eligibility for the program or concerning claims that have been denied in part or in whole, the Contractor's local CoverRx support team shall provide any information requested by the State to make an appropriate response to the inquiring party.
5. **CoverRx Drug Reimbursement.** The Contractor shall use the TennCare Ambulatory Pharmacy Network described in Section A.48 above. The Contractor shall manage a weekly pharmacy provider reimbursement process for adjudicated claims, and provide rebate management services for current and future identified manufacturers, including rebate contracting, invoicing, payment posting, and dispute resolution. The Contractor shall apply a "lesser of" pricing formula that enables the lower of: AWP-15% +dispense fee (brands and generics); MAC; and Usual and Customary. Formula pricing includes a \$3.00 or \$5.00 co-pay for medications on the CDL and 100% co-pay for medications on the discount list. If a medication is not on either list, then the Contractor shall apply Usual and Customer pricing only.
6. **Response to Inquiries, Correspondence, and Complaints.** The Contractor shall maintain a full service staff to respond to inquiries, including, but not limited to, pricing correspondence, complaints, and problems, and to assist with participant and provider education. The Contractor shall assist the State with member inquiries, as requested, that may include accessing claims history and follow-up with pharmacy or members, as applicable.
7. **CoverRx Call Center.** The Contractor shall provide adequate Call Center staff to handle CoverRx call volume. With the State's prior written approval, Contractor's TennCare Program Call Center staff may service both TennCare Program and CoverRx Program calls; however a separate CoverRx telephone number shall be provided by TennCare and shall be utilized by Contractor. The State shall have sole discretion regarding consent to use shared Contractor staff to service the TennCare and CoverRx Call Centers, and, if given, the State may revoke such consent at any time by providing thirty (30) day advance written notice to Contractor. The Contractor shall provide front-end phone messaging to support CoverRx services in the greeting, and shall provide for caller identification and call routing in that front-end messaging for CoverRx callers. Because CoverRx call volume may increase over the term of the Contract, the Contractor shall maintain adequate staff levels to meet the standards for average speed to answer a call and average caller queue time established elsewhere in this Contract. The Contractor shall track calls and maintain data so as to be able to provide the following management reports containing, at a minimum, the following information:
 - (a) Number of calls received;
 - (b) Number of calls abandoned;
 - (c) Number of calls answered;
 - (d) Average speed to answer a call;
 - (e) Average caller queue time; and
 - (f) Average call duration.

A.55.b. CoverRx Services Implementation Plan Overview.

Implementation of the CoverRx portion of this Contract shall be conducted as series of defined phases described below, with the date on which the Contractor is to assume full

responsibility for operation of CoverRx PBM scheduled to be 12:01 A.M. (CT) on January 1, 2020. The Contractor shall be required to complete all the tasks, obligations and responsibilities listed under each phase by the dates identified in the CoverRx Project Plan which shall be developed by the Contractor and an implementation contractor procured by the State (Implementation Contractor) and submitted to the State for review and approval. The CoverRx Project Plan shall be prepared using in Microsoft Project, or such other program as the State may direct, and shall include a detailed timeline description of all work to be performed both by the Contractor, Implementation Contractor and the State. The CoverRx Project Plan shall also include a description of the participants on the Contractor's, Implementation Contractor's and the State's transition teams and their roles and schedules of meetings.

A.55.c. CoverRx Project Initiation and Requirements Definition Phase. The State shall conduct a CoverRx project kick-off meeting. All of Contractor's Key Staff and project staff shall attend. State staff shall provide access and orientation to the CoverRx Pharmacy Program and system documentation. During this phase, the Contractor shall develop the documentation identified below and submit it to the State for review and approval accordance with the CoverRx Services Implementation Plan Schedule:

1. Functional and Informational Requirements (FIR) Document. This document shall include detailed requirements for all CoverRx Point-of-Sale (POS), eligibility application processing, and member database functionalities required by the RFP and/or contained in the Contractor's proposal and/or this Contract. Auto-enrollment eligibility interfaces between CoverRx and TennCare, in a format to be specified by the State, shall be provided at no additional cost to the State if the auto-enrollment process is initiated by the State. All outbound files from the State relating to TennCare and pertaining to auto-enrollment must be loaded to the Contractor's CoverRx data base within twenty four (24) hours of receipt from the State. This requirement includes any transactions that must be handled manually by the Contractor.
2. Data Dictionary. For each data field this shall indicate content, size, values, structure, edit criteria and purpose.

A.55.d. CoverRx System Analysis/General Design Phase. After approval of the documentation by the State required in the Project Initiation and Requirements Definition Phase per Contract Section A.55.c, the Contractor shall develop the General System Design Document and submit it to the State for review and approval in accordance with the CoverRx Services Implementation Plan Schedule. The General System Design Document shall include the following information:

1. An Operational Impact Analysis that details the procedures required to enable the Contractor's system, and the "switch" systems used by pharmacy providers to work effectively together.
2. A Software Release Plan that sets forth the project's implementation into production. This document shall explain procedures for coordinating system changes that shall have an operational or information impact on CoverRx POS operations. It shall detail how CoverRx POS software releases are tested and coordinated. The plan shall include initial implementation of the CoverRx POS system.

A.55.e. CoverRx Technical Design Phase.

The Contractor shall develop the documentation and plans identified below and submit them to the State for review and approval in accordance with the CoverRx Services Implementation Plan Schedule:

1. Preliminary System Interface Design Overview Document;

2. Unit Test Plan that includes test data, testing process, and expected results;
3. Back-up and Recovery Plan that includes processes for daily backup and recovery of system information;
4. Final Disaster Recovery Plan;
5. Information Security Plan that includes how the Contractor shall maintain confidentiality of CoverRx data. This document shall include a comprehensive Risk Analysis;
6. System, Integration, and Load of initial and ongoing eligibility/enrollment data from TennCare's current PBM to the Contractor and Test Plan; and
7. Final System Interface Design Overview Document to be completed after the Contractor has conducted a review of all previous design documents.

A.55.f. CoverRx Development Phase

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

1. CoverRx POS System Test to validate the appropriate adjudication of a claim which shall include a description of the test procedure, expected results, and actual results;
2. Integration Testing shall test external system impacts including provider POS systems and all interfaces. It shall include a description of the test procedure, expected results, and actual results;
3. Load and Stress Testing shall include volume and efficiency to ensure that the system is able to process the volume of CoverRx pharmacy claims. It shall include a description of the test procedure, expected results, and actual results; and
4. Final User Acceptance Testing (UAT).

A.55.g. CoverRx Implementation/Operations Phase

During this phase the Contractor, Implementation Contractor and the State shall assess the operational readiness of all required system components including, but not limited to, the CoverRx POS, and required communications links with the pharmacy "switch" providers. This shall result in the establishment of the operational production environment in which all CoverRx pharmacy claims shall be accurately and reliably processed, adjudicated and paid. The State shall have final approval for all elements of the operational production environment. The Contractor shall coordinate with the Implementation Contractor to develop the documentation and deliverables identified below and submit them to the State for review and approval in accordance with the CoverRx Services Implementation Plan Schedule. The Contractor shall not proceed to the subsequent phase without receiving said approval. The Contractor shall be responsible for timely submitting the following deliverables:

1. Operations Procedures shall be developed and prepared for all procedures and operations performed by Contractor, including but not be limited to, automated operations, data entry operations, Call Center/Help Desk operations, check and remittance fulfillment and member notifications;
2. Production and Report Distribution Schedules shall be developed;
3. Operations Training Plan shall be updated;
4. Training Materials for State staff, pharmacy providers, and other identified stakeholders shall be developed;
5. Training Sessions shall be scheduled and the Contractor shall conduct training sessions for State staff, pharmacy providers, and other identified stakeholders;
6. A Final Conversion Plan shall be developed by Contractor. This plan shall, at a minimum, contain the following activities and projected dates on which each activity shall occur:
 - (a) Loading fifteen (15) months of claims history from CoverRx's outgoing PBM Contractor's POS system into the Contractor's POS system;
 - (b) Migrating current overrides and grandfather provisions, if any, with their end dates into the Contractor's POS system from CoverRx's outgoing PBM Contractor's POS system; and
 - (c) Running other conversion programs, performing manual functions, performing quality control, reporting on outcomes, and converting files in preparation for CoverRx system operation.
7. Final Conversion Activities shall be performed by Contractor pursuant to the approved Final Conversion Plan.

A.55.h. CoverRx Readiness Review

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

1. Benefit plan designs loaded, operable and tested;
2. Perform comprehensive systems testing (including interface testing with all third parties) and quality assurance audits, with results reported to the State prior to the CoverRx Go-Live;
3. Eligibility feed formats loaded and tested end to end;
4. Approved plan for transferring current Call Center/Help Desk toll-free numbers from current TennCare PBM contractor to the Contractor;
5. Signed agreements for Retail Pharmacy networks;
6. Account management and Help Desk staff hired and trained;
7. Established billing/banking requirements;

8. Complete notifications to pharmacies and prescribers regarding contractor change;
 9. Each component shall be met by an agreed upon deadline in an implementation timeline provided by Contractor to the State. Implementation action requirements may include other items necessary to meet the claims processing commencement date of January 1, 2020 at 12:01 A.M. CT; and
 10. Claims history and overrides shall be migrated to Contractor's POS system.
- A.55.i. Remedies Related to CoverRx Implementation Plan and Readiness Review Failure. The Contractor shall produce all required CoverRx Implementation Plan and Readiness Review deliverables and complete all activities by the due dates indicated on the CoverRx Implementation Plan Schedule, in a timely manner and to the satisfaction of the State. Failure to do so shall constitute a material breach of this Contract, and the State may initiate the Termination for Cause provisions located in Section D.6. or take such other actions and seek such other remedies as are available to it pursuant to this Contract, or at law, or in equity.
- A.55.j. CoverRx PBM Services Implementation Plan and Readiness Review Schedule. Within twenty (20) days of the Effective Date of this Contract, the Contractor shall submit a CoverRx PBM Services Implementation Plan and Readiness Review Plan (CoverRx Services Implementation/Readiness Plan) containing all necessary deliverables and activities with projected dates for delivery and/or completion of these items. Upon approval of the CoverRx Project Plan by the State, TennCare will direct the Contractor to begin work on the CoverRx Services Implementation/Readiness Plan through a Control Memorandum and Control Directive in which all deliverable and activity due dates match the dates in the approved CoverRx Project Plan. The State reserves the right to further revise the due dates for the CoverRx Services Implementation/Readiness Plan deliverables and activities and to add additional deliverables and activities, as deemed necessary in the State's sole discretion to be in the best interest of the CoverRx Program. Time is of the essence in the satisfactory completion of all CoverRx Services Implementation/Readiness Plan deliverables and activities by the due dates contained in the revised State approved CoverRx Project Plan.
- A.56. CoverRx Point-of-Sale (POS) System
- A.56.a. CoverRx POS System Overview. The Contractor shall provide an online pharmacy POS system that can be modified to meet the needs of the CoverRx Program. The Contractor shall provide system design and modification, development, implementation and operation for the CoverRx-POS system. The Contractor's POS system shall allow it to interface with the existing pharmacy "switch" networks that connect the pharmacy providers with the Contractor's system.
1. The Contractor shall ensure that within ninety (90) days of implementation of the CoverRx Program, ninety-five percent (95%) of all CoverRx participants will have access to one (1) retail pharmacy within thirty (30) miles of participants' residence, as measured by the GeoNetworks® Accessibility OverView Analysis, or such other software program as the State may specify.
 2. The Contractor shall be responsible for operating the provided system that automates the entire pharmacy claims processing system for the complete pharmacy benefit for all CoverRx enrollees. All payments for pharmacy claims shall be made through the Contractor's system and electronically invoiced to the State weekly as a pass through cost.

3. The source of the claims shall be enrolled network pharmacy providers. All claims shall be submitted through point-of-sale telecommunications devices. Prospective Drug Utilization Review (Pro-DUR) functions provided by the Contractor through the CoverRx-POS system shall alert pharmacists when several defined conditions are present. The Contractor shall recommend to CoverRx new Pro-DUR edits that improve quality and reduce pharmacy program costs. Pro DUR edits shall be customizable to allow for any adjustments recommended by CoverRx's Director.

A.56.b. CoverRx Claim Adjudication Services - General Requirements

1. This section defines claim adjudication requirements for all CoverRx pharmacy claims. All claims adjudicated as payable shall be for eligible members to enrolled or appropriate providers for approved services and in accordance with the payment rules and other policies of CoverRx.
2. The Contractor shall distribute and mail CoverRx outputs (hard copy and electronic) as directed by the State, including but not limited to provider checks and remittance advices (PAs), returned claims, notices, provider bulletins, provider manuals and special mailings. Every Friday, with the exception of weeks during which the State is officially closed due to a holiday or for any other reason (holiday weeks), the Contractor shall mail checks and Remittance Advices for claims submitted through its POS online pharmacy claims processing system for that work week. In the case of holiday weeks, the Contractor shall notify pharmacy providers if a schedule change is to occur at least two (2) weeks in advance and issue checks and remittance advices within two (2) business days of the routine date. The Contractor shall use first class rate for all CoverRx mailings, unless otherwise directed by the State. Postage costs incurred by the Contractor shall be treated as pass-through costs. Such costs shall be billed on a monthly basis to the State in addition to regular invoices and shall include substantiating documentation. Each batch shall have its own reconciliation and money remits. No overhead, administrative or other fee shall be added to such pass-through costs. Printing and supply costs for check and remittance mailings are to be included in the base rate of this Contract. The Contractor shall be responsible for system messages and notice of claims being adjudicated payable, denied or rejected. Claims denied or rejected shall return situation specific messages to assist pharmacies with resubmissions.
 - (a) Cash flow – For checks to be issued on Friday, the Contractor shall deliver the following two (2) files to the State, or its designees, in an electronic media suitable to the State, by 10:00 a.m. Central Standard Time, on Tuesday of each week:
 - (1) All transactions, (i.e., claims, financial adjustment, etc.) identified by the Contractor, that comprise the payments to be issued for Friday of that week. In cases of holidays the Contractor shall notify pharmacy providers if a schedule change is to occur at least two (2) weeks in advance and issue checks and remittance advices within two (2) business days of the routine date.
 - (2) All payments, (check register) identified by the Contractor, to be made on Friday of that week. The State shall be notified as required by Contract Section A.33 of any systems or operational issues that may impact disbursements by the prescribed time lines. The file described in (i) above shall contain all transactions that make up the payments in the file described.
 - (b) The State reserves the right to review the files prior to issuing payment and to hold or adjust any payment that is not satisfactory to the State. The Contractor is required to offer automatic deposit to its providers. If the Contractor submits a claims payment request and the State overpays the

claim, the State reserves the right to withhold the overpaid monies. The Contractor shall be responsible for providing Remittance Advices (RAs) to providers unless the provider elects not to receive hardcopy RAs. RAs shall be included in payments by the Contractor to providers. The Contractor shall comply with the American National Standards Institute Care Claims Payment and Remittances Advice Format known as the "ANSI 835". The ANSI 835 is a HIPAA compliant format. The Contractor shall ensure that any payments funded by CoverRx are accurate and in compliance with the terms of this Contract, agreements between the State or Contractor and providers, and state and federal laws and regulations.

- (c) To the extent that the Contractor compensates providers on a fee for service or other basis requiring the submission of claims as a condition to payment, the Contractor shall electronically process the provider's claims for covered benefits provided to members consistent with applicable CoverRx policies and procedures and the terms of this Contract. The Contractor shall mail checks and RAs to pharmacy providers weekly on Fridays for all claims submitted through the POS online pharmacy claims processing system and for all batch claims. In the case of holiday weeks, the Contractor shall notify pharmacy providers if a schedule change is to occur at least two (2) weeks in advance and issue checks and RAs within two (2) days of the routine date.
- (d) The Contractor shall: (1) process ninety-nine and a half percent (99.5%) of POS claims on a daily basis within ten (10) seconds of receipt by the Contractor's processor, and, (2) if appropriate, pay within fifteen (15) days of receipt one hundred percent (100%) of all clean claims submitted by network and non-network pharmacy providers through POS and batch electronic claims submission. The term "pay" means that the Contractor shall either send the provider cash or cash equivalent in full satisfaction of the clean claim, or give the provider a credit against any outstanding balance owed by that provider to the Contractor. The Contractor shall pay the clean claim or advise the provider that a submitted claim is: (1) a "denied claim" (specifying all reasons for denial); or, (2) an "incomplete claim" that cannot be denied or allowed due to insufficient information and/or documentation (specifying in detail all information and/or documentation that is needed from the provider in order to allow or deny the claim). An incomplete claim may be resubmitted with the information necessary to complete the claim. This resubmission shall constitute a new claim only for the purpose of establishing a timeframe for claims processing. The Contractor shall develop, maintain and distribute to pharmacy providers a pharmacy procedure and billing manual. Manuals shall be posted on the Contractor's dedicated CoverRx website and distributed to pharmacies with acknowledgement of network participation. The manuals shall provide instructions to providers regarding the process by which the provider receives payment, in order to diminish the potential for incorrect billing and the need for adjustments or recoupments. The content of the manuals shall be approved by the State before distribution.
- (e) The Contractor shall be responsible for processing all CoverRx pharmacy claims through a POS system using the specified, current NCPDP format. Pharmacy claims shall be priced and adjudicated in an online, real time POS system that results in a claim pay status of pay, deny or reject. The system must allow a pharmacy to initiate a reversal (void) of a submitted claim. The telecommunications system supporting the POS function shall be available for claims submissions by pharmacies twenty-four (24) hours-a-day, seven (7) days-a-week (except for regularly scheduled and separately approved downtimes). The Contractor shall not charge pharmacies a POS transaction fee. CoverRx providers are responsible for purchasing POS hardware, software and all telecommunications linkages. The POS function shall be required of all pharmacy providers.

A.56.c. CoverRx Claims Receipt and Management

1. The Contractor shall receive electronic point of sale (POS) claims. The Contractor shall apply a unique identification number to each claim and any supporting documentation regardless of submission format. The identification number shall be used to recognize the claim for research or audit purposes. Control totals shall be utilized to ensure that all claims have been processed to completion. The Contractor shall establish appropriate safeguards to protect the confidentiality of CoverRx and enrollee information.
2. At the point of sale, the Contractor shall identify and deny claims that contain invalid provider numbers. This shall include cases where the number is missing, the check digit fails, or the provider number does not identify an entity to receive a Remittance Advice. Claims that contain these errors shall be returned to the originating provider. Pharmacy Providers shall submit claims and be identified by their individual and specific NPI (National Provider Identification) numbers. Prescribers shall be identified on all pharmacy claims by their specific NPI.
3. The Contractor shall be held to the following POS Claims timeline requirements:
 - (a) The Contractor shall process ninety-nine and a half percent (99.5%) of POS claims on a daily basis within ten (10) seconds. This is the time from when the claim is received by the Contractor's processor to the time the results are transmitted from the Contractor's processor and shall include all procedures required to complete claim adjudication.
 - (b) The Contractor shall notify the State within one hour (1) of sub-standard system performance.
4. The Contractor's system shall operate without unscheduled or unapproved downtime. The Contractor shall report to the State immediately (within one (1) hour) upon knowledge of unscheduled or unapproved downtime. A system down or "downtime" shall be defined as an interruption involving more than ten percent (10%) of production for a period greater than fifteen (15) minutes. The Contractor shall also provide the State updates at regular intervals during a sustained downtime. The State shall be presented with recovery options as appropriate. Upon full system recovery, the Contractor shall provide the State with a System Downtime Analysis describing root cause issues and actions to mitigate future downtime occurrences within five (5) business days after full system recovery.
5. The Contractor shall ensure that collection letters are sent to contracting pharmacies that maintain an accounts-payable balance to the State greater than ninety (90) days. These notices shall be sent within five (5) business days of becoming ninety (90) days old. The Contractor shall provide the State with a monthly report of notices sent, due within ten (10) business days after end of month of reporting period. Postage costs incurred by the Contractor shall be treated as pass-through costs. In addition to regular invoices, these costs shall be billed on a monthly basis to the State and shall include any necessary substantiating documentation. Printing and supply costs for collection mailings shall be included in the base rate of this Contract.
6. The Contractor shall provide TennCare Fiscal Services Unit a report detailing all checks remitted to contracted pharmacies on behalf of the State that remain outstanding (that have not been cashed) more than ninety (90) days. Reports are due monthly on the fifteenth (15th) day of the month following the reporting period.
7. Call Center/Help Desk for System Support - The Contractor shall maintain toll-free telephone access to support system operations. This Call Center/Help Desk shall be available twenty-four (24) hours a day, seven (7) days a week to respond to

questions and problems from providers regarding system operations and claims inquiries. The Contractor shall supply all the required information systems, telecommunications, and personnel to perform these operations. In no event should the Contractor use off shore sites for any area of performance of this contract. The Contractor's Pharmacy Call Center/Help Desk services shall include pharmacy provider and member call services, mirroring the service level agreements (SLAs) of the TennCare Medicaid program. These phone lines shall be operated in accordance with Contract Section A.55.

A.56.d. CoverRx Data Validation Edits and Audits

1. The system shall screen all claims and apply all State approved and required data validation procedures and edits. Consistency controls shall be in place to ensure that dates, types, and number of services are reasonable and comply with CoverRx policy and/or rules. Should the State determine, in its sole discretion, that changes in the control measures are necessary, the State may instruct the Contractor to modify the control measures. The Contractor shall perform any work necessary to effect a requested change in control measures at no additional cost to the State.
2. The Contractor shall immediately notify the State of any and all claims that have been erroneously processed, and initiate appropriate action to correct the errors (e.g., adjustments, recoveries, etc.). Incorrect claims include, but are not limited to: claims paid for ineligible members; claims paid to a terminated provider; claims paid for duplicate services; claims paid for a non-covered service; and claims paid at an incorrect rate or claims that denied or rejected inappropriately. The Contractor shall follow-up such notification to the State by letter for any system errors that resulted in provider overpayment or other incorrect payment. The Contractor shall reimburse the State for the cost of all claims paid as a result of Contractor error. Reimbursement or damages resulting from this Section may be applied as offsets to future administrative fees.
3. Using an industry-accepted standard, the Contractor shall define the categories of data elements such as brand/generic classification, therapeutic categories, and OTC classification. The Contractor's system shall permit the State to override these values using its own policies/procedures.
4. The Contractor shall establish a system capable of adding, changing, or removing claim adjudication processing rules. At no additional cost to the State, the Contractor shall add, change, or remove claim adjudication rules in its system to accommodate changes that the State determines, in its sole discretion, to be necessary or required.
5. The State reserves the right to override any system edit whenever it deems appropriate and necessary.
6. Throughout the term of this Contract, the Contractor shall be responsible for making recommendations to the State regarding the need for the edits, associated criteria and call center protocol development. The Contractor and State staff shall agree upon criteria to produce a retrospective report containing findings and recommendations for prevention of such practices.
7. CoverRx Valid Dates of Service - The system shall ensure that dates of services are valid dates, are no older than ninety (90) days from the date of the prescription (unless approved by the State) and are dates that have already occurred (not dates in the future).
8. CoverRx Duplicate Claims - The system shall automatically inform the provider that the current claim is an exact or possible duplicate and deny that claim as appropriate.

9. CoverRx Prescription Validity - The system shall ensure that the time period for a prescription has not expired and that the number of valid refills has not been exceeded.
10. CoverRx Covered Drugs – Unless otherwise directed by the State, the system shall verify that a drug code (NDC) is valid and the drug is eligible for payment under the CoverRx pharmacy program and eligible for Contractor negotiated CoverRx drug rebates.
11. CoverRx Provider Validation - The system shall approve payment only for claims received from providers who are eligible to provide pharmacy services, and for CoverRx and non-CoverRx providers who are authorized (as required by the State) to prescribe pharmaceuticals. The system shall be populated with current, updated pharmacy and prescriber provider location and contact information. The system shall be capable of customizing prescriber networks upon the State's request, and accepting prescriber provider files from the State in a mutually agreed upon format. The system shall have the capability to determine whether the prescriber is a network provider, and reject claims based on the provider's network status, if requested by the State. The system shall also have the capability to report on claims (both paid and rejected) based on provider status, whether in-network or out-of-network.
12. CoverRx Recipient Validation – A Valid Claim is a claim for service for those members eligible to receive pharmacy services at the time the services were rendered. The system shall approve only Valid Claims. The State shall transmit auto-enrollment information to the Contractor by the standard HIPAA compliant files as defined by the State for the purpose of auto-enrolling members into CoverRx. The State shall be responsible for assuring that the auto-enrollment file provided is accurate and complete. The Contractor shall use this information to auto-enroll (within one (1) business day) individuals identified by the State. The NCPDP Post Adjudication Standard 4.5 format shall be used for encounter reporting sent to the State. If the Contractor has been billed for any claims for a recipient who was deceased at the time the service was allegedly provided or who is no longer eligible for CoverRx, then the Contractor shall be required to recoup monies paid to any provider and to repay any monies collected by the Contractor for the claims that were paid post date of death or post eligibility for enrollment. On an as needed basis, the Contractor shall report the amount recouped by the Contractor and the amount to be repaid to the State. In addition, the Contractor shall reimburse the State promptly for monies owed to the State as a result of billing for recipients not eligible to receive services.
13. CoverRx Quantity of Service - The system shall validate claims to ensure that the quantity of services is consistent with CoverRx policy and/or rules (i.e., verify that drug specific minimum and maximum quantity limitations, as well as days' supply and number of prescriptions per month limitations are followed as described below:
 - (a) Participants will pay a Co-Pay at point of sale as established by the State and provided to the Contractor; and
 - (b) Limits - Participants are subject to a five (5) prescription limit per month. Insulin and diabetic supplies are excluded from the prescription limit.
14. CoverRx Rejected Claims - The system shall determine whether a claim is acceptable for adjudication and reject claims that are not.
15. CoverRx Early Refills - The systems shall be able to recognize when an enrollee attempts to refill a prescription (either the original prescription or a new prescription for the same drug) and require that eighty-five percent (85%) or any other percentage threshold as directed by the State, of the original days' supply has passed since the

original filling. Overrides at the pharmacy level shall be permitted by the Contractor's Help Desk for drug categories as directed by the State, but monthly reports shall identify the enrollee and the pharmacy provider where such overrides occurred.

16. CoverRx Co-pay Edit – The Contractor shall add co-pay edits into the POS system pursuant to the co-pay structure provided by the State.
17. CoverRx Usual and Customary (U&C) Edit – Reimbursement logic shall compare the sum the ingredient cost and dispensing fee as determined by the State to the submitted (U&C) amount and pay the less amount.
18. CoverRx Prescriber Number Edit - The POS claims processing system shall be configured to require that all claims shall be submitted with the prescriber's NPI number. The validity of NPI numbers shall be determined by the most current data available from the National Technical Information Service.
19. CoverRx Unit of Measure Edit - The Unit of Measure (UOM) edit shall perform two (2) main functions:
 - (a) Check incoming claim units (i.e., gram, milliliter, etc.) versus the units listed in Reporting System for that particular NDC; and
 - (b) Verify that the unit amounts transmitted is consistent with the unit amounts in Reporting System. The submitted quantity shall be a multiple of the unit size shown in Reporting System (i.e., claim shall be rejected if unit amount transmitted has been rounded). For example, the units transmitted is fourteen (14), but the unit amount is thirteen point seven (13.7) in the Reporting System.
20. CoverRx Prescriber Last Name Edit -The claims processing system shall be set to ensure that the submitting prescriber's last name correctly matches the last name associated with the NPI number.
21. CoverRx Maximum Dollar Amount Edit – All pharmacy claims over a specified dollar amount per claim shall reject at the POS and the pharmacy provider shall be required to call the Contractor Call Center regarding rejected claims. This includes a one thousand five hundred dollar (\$1,500) limit on non-compounded, non-exception claims. The Contractor's system shall be capable of adding, changing, or removing maximum dollar edit rules at no cost to CoverRx when requested by CoverRx.

A.56.e. CoverRx Prospective Drug Utilization Review (Pro-DUR)

1. The Contractor shall duplicate the TennCare Prospective Drug Utilization Review (Pro-DUR) system for the CoverRx Program. The Pro-DUR function shall meet minimum TennCare Drug Utilization Review (DUR) requirements as well as the additional specifications in this section and be flexible enough to accommodate any future edit changes required by the State. The Contractor's system shall provide Pro-DUR services that apply State-approved CoverRx edits to all claims. The edits shall determine problems with a prescription and shall validate medical appropriateness of the prescribed drug by comparing the circumstances surrounding the request with established pharmacy-related therapeutic criteria.
2. The Contractor's POS system shall be capable of applying results of Pro-DUR processing in the claim adjudication process. Claims that reject as a result of Pro-DUR processing shall include situation specific messaging and error codes that enable the pharmacy provider to take appropriate actions. The Contractor may use an existing Pro-DUR package but shall be prepared to make any modifications required by the State. The Contractor shall work with the State in setting the

disposition of Pro-DUR edits. The Contractor's system shall include the following minimum prospective drug utilization review (Pro-DUR) features at installation:

3. CoverRx Potential Drug Problems Identification - The Contractor's system shall accept and use only State-approved CoverRx criteria and shall perform automated Pro-DUR functions that include, but are not limited to:
 - (a) Automatically identify and report problems that involve potential drug over-utilization;
 - (b) Automatically identify and report problems that involve therapeutic duplication of drugs when the submitted claim is associated with other drugs or historical claims identified for a given enrollee;
 - (c) Automatically identify and report problems that involve drug use contraindicated by age, gender and presumed diagnosis codes on historical claims for a given enrollee;
 - (d) Automatically identify and report problems that involve drug use contraindicated by other drugs on current or historical claims for a given enrollee (drug-to-drug interactions);
 - (e) Automatically indicate and report the level of severity of drug/drug interactions;
 - (f) Automatically identify and report potentially incorrect drug dosages or limit the quantity per prescription to ensure the most cost-effective strength is dispensed.
 - (g) Automatically identify and report potentially incorrect drug treatments;
 - (h) Automatically indicate and report potential drug abuse and/or misuse based on a given members prior use of the same or related drugs; and
 - (i) Automatically identify early refill conditions and provide, at the drug code level, the ability to deny these claims;
4. CoverRx POS Provider Cancel or Override Response to Pro-DUR Messages – Prior to the final submission of POS pharmacy claims, the Contractor's system shall automatically generate Pro-DUR messages in a manner that shall enable a pharmacy provider to cancel submission of the claim or to submit it if it is a message that can be overridden.
5. CoverRx POS Provider Comment on Pro-DUR Messages - The Contractor's system shall allow providers to enter responses utilizing NCPDP Professional Pharmacy Services (PPS) intervention codes in response to Pro-DUR messages. The system shall capture and store all NCPDP standard DUR conflict, intervention, and outcome messages for reporting to the State. The Contractor shall make changes to the PPS intervention configuration as directed by the State at no cost to the State.
6. CoverRx Flexible Parameters for Generation of Pro-DUR Messages - The Contractor's system shall have the ability to transmit new or revised Pro-DUR messages and to define the Pro-DUR criteria that activate these messages. The system shall maintain a State-controlled set of parameters to the situations involving generation of online Pro-DUR messages. The system shall provide and permit the use of all general system parameters regarding data access, support, and maintenance. Variables subject to State definition and control include, but are not limited to: NDC code (including multiple NDC codes subject to potential drug/drug

interaction); date of service; drug strength; drug quantity; daily supply; and Generic Product ID (GPI), Generic Drug Code (GCN) or Generic Sequence Number (GSN).

7. CoverRx Pro-DUR Enrollee Profile Records - The Contractor's system shall provide and maintain enrollee profiles for Pro-DUR processing of submitted claims. Recipient profiles shall be based on inferred and actual diagnoses from pharmacy claims and other data available.
8. CoverRx Disease/Drug Therapy Issues Screening - The Pro-DUR system shall have the capability to screen for drug therapy concerns by specific drugs relative to high-risk disease, to include but not limited to: cardiovascular disease; cerebrovascular disease; central nervous system disease; renal disease; endocrine disease; gastrointestinal disease; psychiatric disease; and respiratory disease.
9. CoverRx Patient Counseling Support - The Contractor's system shall present Pro-DUR results to pharmacy providers in a format that supports their ability to advise and counsel members appropriately. The system shall be able to print out these instructions for the member.

A.56.f. CoverRx Prescription Limits

1. The Contractor shall restrict the maximum number of claims per month that recipients can receive under the CoverRx benefit package. The limit restricts dispensing of drugs on the Covered Drug List to the specified limit with the exception of drugs included the Auto Exemption list developed by the State. As of the beginning date of this Contract, the prescription limit is calculated on a monthly basis and is set at five (5) prescriptions per month.
2. CoverRx Prescription Limit Overrides - The Contractor shall support a mechanism for allowing enrollees to get prescriptions beyond the limit. An Auto-Exemption List, shall be developed by the State and shall include products that shall never count against the prescription limit. The Contractor shall be responsible for developing the process to support both long and short term override capabilities.
3. The Contractor shall support any changes to the prescription limit process including, but not limited to: changes in the five (5) prescription limit; changes in the Auto-Exemption list at no additional cost to CoverRx.

A.56.g. CoverRx Pharmacy Claim Processing and Payments. The system shall process claims in accordance with existing CoverRx policy and rules and Tennessee regulations for dispensing fees.

1. All payments for pharmacy claims shall be made through the Contractor's system and electronically invoiced to the State weekly. A pharmacy claim is a request for payment for a specific drug, typically at the NDC code level. An adjudicated pharmacy claim is one that has been processed to either a Payable or Denied status. An adjudicated claim also includes a claim that has been previously rejected and resubmitted by the provider and is later deemed either Payable or Denied.
2. Claims pricing is driven by the pricing methodologies described by CoverRx rules and policies. Currently Average Wholesale Price minus fifteen percent (15%) is the payment for brand name and non-MAC'd medications. The system shall compare the calculated allowed price (i.e., quantity multiplied by price plus the dispensing fee) to the billing charge and authorize payment based on the current CoverRx pricing methodology. The Contractor's system shall allow for price adjustments submitted by the CoverRx Director to be effective within two (2) business days.

CoverRx's claim pricing for generics and multi-source brands is based on the MAC pricing provided by the Contractor. The Contractor shall ensure that MAC pricing

suggested to the State reflects current market conditions and price fluctuations. The Contractor shall provide documentation to the State upon request for any MAC price suggested to the State.

3. The system shall recognize all applicable copays and deduct that amount from the payment made to the pharmacy provider.
4. For the purposes of this Contract, an adjudicated claim shall not include a point-of-sale transaction that was canceled by the sender or a claim that was rejected before it could be fully adjudicated.
5. The Contractor shall be responsible for the preparation of any applicable tax information for service provider payments and the federal government (i.e., Form 1099).
6. The Contractor shall be able to support any/all changes to discount rates and standard pharmaceutical pricing methodologies and incorporate them into pharmacy claim pricing policies at the sole discretion of the State with no additional cost.
7. CoverRx Professional Dispensing Fee. The current CoverRx dispensing fee is as follows: Brands: \$2.50; Generics: \$3.00.

A.56.h. CoverRx Reversals and Adjustments

The system shall provide an efficient means of reversing or adjusting claims. The State shall not pay the Contractor for reversed, voided or adjusted claims. The Contractor shall process all reversals requested by TennCare's fiscal unit within thirty (30) days and provide confirmation to the State's fiscal unit upon occurrence.

A.57. CoverRx Covered Drug List (CDL)

- A.57.a. The TennCare CoverRx CDL will be provided to the Contractor during implementation and will be used to manage the CoverRx benefit plan configured in the POS system. The Contractor shall maintain the State's established CDL for the retail and mail order CoverRx program. Changes in the CDL shall be submitted by the State to the Contractor no less than thirty (30) business days prior to change implementation date, unless the Contractor and State mutually agree to a shorter notification time.
- A.57.b. CDL changes will be recommended by the CoverRx Clinical Advisory Committee and final decision made by the CoverRx Director and TennCare Chief Pharmacy Officer. The Contractor shall advise and update the State on all potential changes in the pharmacy marketplace potentially affecting the CoverRx Program's drug spend.
- A.57.c. The Contractor shall implement, administer and maintain a CDL program for CoverRx. On the date the Contractor assumes full responsibility for the pharmacy benefits program, the Contractor shall assume responsibility for administering and maintaining the existing CDL. The Contractor shall prepare and maintain a document suitable for printing or posting to the CoverRx website providing the CDL listing.
- A.57.d. The Contractor shall design, develop, implement, administer and maintain a listing of quantity limits for certain drugs. This list shall be based on therapeutic best practices or opportunities to reduce the cost of the most appropriate dosage form. This list is distinct from the maximum tolerated to dose. Drugs and quantities on the quantity limits listing shall be included in the CDL documents and coded into the CoverRx POS system.
- A.57.e. The CoverRx CDL shall be designed to maximize the prescribing and dispensing of safe and clinically effective drugs within each therapeutic class that are the most cost-effective.

- A.57.f. The Contractor's CDL design shall include a stringent clinical review of clinical guidelines and medical literature to identify which agents and classes of drugs shall be subject to the CDL program. Within the classes of drugs determined to be subject to the CDL, the Contractor shall determine which drugs within each class are safe, clinically effective, and provide equivalent clinical outcomes. Recommendations for inclusion on the CDL shall be based on a thorough review of clinical effectiveness, safety, and health outcomes, followed by an analysis of the relative costs of the drugs in each class under consideration.
- A.57.g. Final decisions about drugs included or excluded from the CoverRx CDL shall be at the sole discretion of the State.
- A.57.h. CoverRx CDL Design, Development, and Implementation
1. The Contractor shall use pharmacoeconomic modeling and evidence-based data in the maintenance of the CoverRx CDL that ensures clinically safe and effective pharmaceutical care and yields the highest overall level of cost effectiveness. The Contractor shall develop and present to the CoverRx Clinical Advisory Committee the clinical and pharmacoeconomic review criteria the Contractor used to make recommendations regarding CDL drugs.
 2. The Contractor shall design, develop and implement an ongoing, broad-based educational effort to ensure that prescribers and pharmacists are fully aware of the CoverRx CDL.
 3. The Contractor shall ensure that the CoverRx-POS pharmacy claims processing system fully integrates the CoverRx CDL.
 4. For the term of this Contract, the Contractor shall comply with all applicable federal and state statutes, regulations, rules and policy requirements and all applicable administrative rules, statutes, policies and guidelines as they may be modified from time to time.
 5. The Contractor shall ensure that the CoverRx CDL program and CoverRx-POS system include provisions to ensure that all prescribers and pharmacy providers have timely and complete information about all drugs on the CoverRx CDL. The Contractor shall make such information available through written materials and internet sites.
 6. The Contractor shall support the management and coordination of all activities related to the maintenance of the CoverRx CDL. Activities shall include but not limited to the following:
 - (a) The Contractor shall present to the CoverRx Pharmacy Advisory Committee clinical reviews of new brand-name drugs and new generic drugs for clinical safety and efficacy, and make recommendations regarding possible inclusion in the CoverRx CDL.
 - (b) The Contractor shall analyze cost information relative to drug alternatives as they affect the CoverRx CDL.
 - (1) The Contractor shall manage the CDL timeline from preparing for the CoverRx Pharmacy Advisory Committee meeting through follow up implementation. This timeline shall be co-developed with the State.
 - (2) The Contractor shall implement changes to CDL, within thirty (30) days of approval from the State. Changes shall include modifications to the POS system and all supporting systems and documents. The State shall approve all documents and identify the targeted providers for each notification.

A.57.i. CoverRx Clinical Advisory Committee

1. The Contractor shall attend, support and facilitate meetings of the CoverRx Clinical Advisory Committee as necessary to maintain the CoverRx CDL. Such support shall include the responsibility to develop drug class reviews, and quantity limits. The Contractor shall coordinate with the State to determine bi-annual dates for in person Committee meetings. The Contractor shall also be responsible for room reservation, distribution of meeting materials, and preparation of meeting minutes. No less than ten (10) business days prior to the scheduled meeting, the Contractor shall have the meeting materials approved by the State and distributed to committee members. Meeting minutes are to be taken by Contractor and the draft copy shall be available for review by the CoverRx Director no more than two (2) weeks after the meeting
2. The Contractor's clinical staff, together with Pharmacy Residents identified by the CoverRx Director, shall present to the CoverRx Clinical Advisory Committee drug reviews for new or existing drugs and new indications that might affect their inclusion in the CoverRx DL during the annual meetings.
 - (a) The primary function of the drug reviews is to assist the State and the CoverRx Clinical Advisory Committee members in determining if certain drugs can be considered therapeutic alternatives.
 - (b) CDL reviews are therapeutic comparisons - CDL drug class reviews should assess a drug's place in therapy,
 - (c) The CDL reviews may also make recommendations for other program initiatives such as development of Pro-DUR criteria and prospective edits.
 - (d) The Contractor shall also participate, support, and facilitate telephone conference meetings based on the schedule set by the Clinical Advisory Committee.

A.57.j. CoverRx Rebate Administration

1. The Contractor shall process, invoice, and collect rebates through the Contractor's rebate administration systems, and shall assume all responsibility for uncollected receivables at the time of the contract date. The Contractor's system shall be capable of payment tracking and reconciliation and dispute resolution for disputes related to rebate unit issues and utilization. The Contractor shall import historical quarterly rebate data into their rebate management system, provided by CoverRx's current rebate vendor. The Contractor shall assume all administrative and management tasks associated with rebates for historical quarters as well as future quarters occurring during the contract period. The Contractor shall generate and issue quarterly invoices for rebates. The Contractor shall provide the designated State staff data files that contain the specific information in the specified format as required by the State. The quarterly rebate invoices shall be generated for all pharmaceutical manufacturers and State approval.
2. The Contractor shall ensure that written notifications are sent to pharmaceutical manufacturers concerning past-due rebate payments for undisputed account balances. Past-due balances shall be identified when they are at forty-five (45), seventy-five (75) and ninety (90) days of delinquency. The Contractor shall provide the State with monthly reports, due ten (10) business days after the end of the month for the reporting period, detailing past-due notifications sent to drug manufacturers.
3. Dispute resolution pertaining to units billed for rebates shall be done by the Contractor. The Contractor shall perform all dispute resolution activities with pharmaceutical manufacturers pertaining to rebate calculations and collections. The

Contractor shall present for State approval remedies for all disputes within ninety (90) days of dispute. The State shall have final approval of all settlements negotiated.

4. One hundred percent (100%) of all monies collected on behalf of the State shall be remitted to the State. The Contractor agrees that all rebates collected on behalf of the State shall be collected for the sole benefit of the State's share of costs, and that no other monies other than rebates shall be collected based on the State's program
5. The Contractor shall provide to the agency or business of the State's choosing, any and all appropriate, accurate, and balanced pharmacy level claims data needed to resolve or avoid any drug rebate disputes. This pharmacy level claims data shall be provided within fifteen (15) business days of the request by the State.

A.58. CoverRx Technical Requirements

A.58.a. CoverRx POS Network Interfaces.

1. At initial system implementation, data transmissions between the CoverRx-POS and the pharmacy providers shall be in National Council on Prescription Drug Programs' (NCPDP) most current version. As updates to the NCPDP format become available, the CoverRx-POS Contractor shall maintain compatibility both with Providers using the updated version and those using the superseded versions. Compatibility maintenance for each superseded version shall continue until the updated version becomes generally available and the State has approved discontinuation of such maintenance.
2. The Contractor shall support pharmacy providers in their interaction with the CoverRx-POS and coordinate with network vendors to ensure smooth operation of the CoverRx-POS with the commercial pharmacy POS environment. At the date of the release of the RFP, there are approximately sixteen hundred (1,600) pharmacy providers in Tennessee in the CoverRx Participating Pharmacy Provider network, along with an additional thirty thousand (30,000) chain and specialty providers outside of Tennessee. The Contractor shall establish testing procedures and certify provider practice management systems (i.e., "switches") as compatible and ready to interface with the CoverRx-POS. The Contractor shall not be required to supply hardware or software to pharmacy providers.
3. The Contractor may not use its position as the CoverRx pharmacy claims processing agent to create barriers to providers, or pharmacy practice management vendors who wish to participate in the CoverRx-POS. The Contractor shall not charge connection or access fee to pharmacies or switching companies.
4. Switch and billing agent functions, if provided by the same company, shall be maintained as separate and distinct operations. If the Contractor acting as the CoverRx-POS Contractor also provides services as the providers' agent, an organizational "firewall" shall be in place to separate these functions.

A.58.b. CoverRx HIPAA Compliance.

1. Pharmacy providers will use NCPDP format for submission of pharmacy transactions. The X12 837 Standard Claim and NCPDP formats were promulgated by the Secretary of Human Services as specified by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
2. The Contractor shall coordinate with the State to ensure that the electronic formats used for the CoverRx-POS conform to present and future regulations as they exist during the term of this Contract. If federal or State laws, rules, regulations or executive orders impose new or different requirements regarding electronic formats

during the term of this Contract, Contractor shall carry out any necessary work to establish compliance at no additional cost to the State.

A.58.c. CoverRx POS Interface Software. The Contractor shall provide software to allow the State to test the Contractor's system through the CoverRx network. During the DDI Phase, the State shall test submission and receipt of NCPDP point-of-sale transactions. After implementation, and during the term of this Contract, the State shall test and audit performance of the system. An ongoing project plan shall be required to coordinate a software release schedule and detail how CoverRx Program efforts are to be coordinated.

A.58.d. CoverRx POS System Availability Requirements.

1. The Contractor shall ensure that the average system response time is no greater than ten (10) seconds for a minimum of ninety-nine and a half percent (99.5 %) of all transactions, seven (7) days per week twenty-four (24) hours per day. Cumulative system downtime shall not exceed two (2) hours during any continuous five (5) day period.
2. The CoverRx-POS system shall be available twenty-four (24) hours per day, seven (7) days per week, for provider inquiry or billing purposes. Such availability shall include all normal forms of entry. The Contractor may have scheduled maintenance downtime that is pre-approved by the State.

A.58.e. CoverRx System Maintenance and Modification Deadlines and Damages. System maintenance problems shall be corrected within five (5) business days or by a State-approved correction date.

A.58.f. CoverRx System Security. The Contractor shall apply recognized industry standards governing security of State Automated Data Processing systems and information processing. At a minimum, the State requires the Contractor to conduct a security risk analysis and the results shall be included in the Information Security Plan provided during the DDI phase. As determined by the State to be appropriate, the following specific security measures may be included in the system design documentation, operating procedures and State agency security program:

1. Computer hardware controls that ensure acceptance of data from authorized networks only;
2. Placement of software controls, at the Contractor's central facility, that establish separate files for lists of authorized user access and identification codes;
3. Manual procedures that provide secure access to the system with minimal risk;
4. Multilevel passwords, identification codes or other security procedures that shall be used by State or Contractor personnel;
5. All CoverRx-POS software changes subject to State approval prior to implementation; and
6. System operation functions segregated from systems development duties.
7. Contractor shall complete a third-party penetration test every three hundred sixty-five (365) days or in the event of a major change in the system. All medium, or higher, risk findings shall be communicated to TennCare Security within one (1) week of the finding. The testing shall, at minimum, include the SANS top ten (10) for the application and database servers with both automated and manual evaluation methods. A penetration testing report must be sent to TennCare Security prior to "go-live".

A.58.g. CoverRx Proprietary and Confidential Information.

1. All proprietary information, including but not limited to, provider reimbursement information provided to the State, shall be deemed confidential and not subject to disclosure under the Tennessee Public Records Act. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of federal law, State law and ethical standards and shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with federal law, State law and ethical standards. Confidential information includes any non-public, confidential or proprietary information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, which is supplied by the State to the Contractor or acquired by the Contractor on behalf of the State under this Contract.
2. CoverRx Confidentiality of Records and Duty to Protect. Strict standards of confidentiality of records shall be maintained in accordance with federal and state laws and regulations and CoverRx policies, procedures and rules. The Contractor shall exercise the same or greater level of care to preserve the confidentiality of the State's information as the Contractor exercises to protect its own confidential information so long as such standard of care does not violate the applicable provisions of the first paragraph of this section. Confidential Information (i) shall be held by the Contractor in strictest confidence at all times; (ii) shall not be disclosed or divulged by the Contractor to any person or entity, except those employees and agents of the Contractor who require access to such information, and only after those employees and agents have been instructed that the information is subject to the confidentiality obligations set forth herein; and (iii) shall not be used by the Contractor for any purpose not set forth herein or otherwise authorized in writing by the State. Contractor shall diligently exercise the highest degree of care to preserve the privacy, security and integrity of, and prevent unauthorized access to, the Confidential Information. Contractor ensures that it has established written policies and procedures relating to confidentiality, including the confidentiality of protected health information and eligibility information. Contractor ensures that it has implemented administrative, technical and physical safeguards and mechanisms that protect against the unauthorized or inadvertent disclosure of confidential information to any person or entity outside its organization not in accordance with this Agreement.
3. The Contractor shall maintain the confidentiality of CoverRx member information. Any information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, relating to individuals enrolled in the CoverRx program ("CoverRx enrollees"), or relating to individuals who may be potentially enrolled in the CoverRx program, which is provided to or obtained through the Contractor's performance under this Agreement, shall also be treated as confidential information to the extent that confidential status is afforded such information under State and federal laws or regulations. The Contractor shall ensure that access to this information shall be limited to the Contractor. The Contractor shall take measures to prudently safeguard and protect unauthorized use and/or disclosure of CoverRx member information in its possession. The Contractor shall establish internal policies to ensure compliance with federal and state laws and regulations regarding confidentiality including, but not limited to, 42 Code of Federal Regulations (CFR) § 431, Subpart F, 42 United States Code Annotated (USC) §§ 1320d, *et seq.*, all applicable Tennessee statutes and CoverRx rules and regulations. In no event may the Contractor provide, grant, allow, or otherwise give, access to CoverRx member information to anyone without the express written permission of the State. In the event that information is used and/or disclosed in any manner, the Contractor shall assume all liabilities under both State and federal law.

4. The Contractor shall immediately notify the State of any and all occurrences where CoverRx's confidential information may have been breached and initiate appropriate action to prevent subsequent breaches.

A.58.h. CoverRx Third Party Administrator Requirement

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

A.58.i. CoverRx Member Identification Cards.

1. The Contractor shall provide each CoverRx member with a pharmacy benefit identification (ID) card. This shall occur at least three (3) weeks prior to the commencement of the Contractor processing claims. The card shall comply with all state laws and NCPDP guidelines, as amended, regarding the information required on the card, as well as any other information required by the State, and must be approved by the State. In no event shall the Contractor print or otherwise include the individual CoverRx enrollee's Social Security Number on any identification card required for the individual to access products or services provided under this Agreement. The Contractor shall provide pharmacy benefit identification cards for new CoverRx members added to the CoverRx eligibility file on an ongoing basis. The Contractor shall establish a process that allows enrollees to request replacement cards. Replacement and new cards shall be produced and mailed by the Contractor on the 15th day of each month.
2. The Contractor shall establish and maintain a process to produce ID cards for new enrollees and issue replacement ID cards upon request from a CoverRx enrollee. The Contractor shall be reimbursed for actual postage costs. Such costs shall be billed on a monthly basis to the State in addition to regular invoices and shall include substantiating documentation. The cost related to the production of the identification cards shall be included in the Contractor's base rate in this Contract.
3. Other mailings pursuant to this Contract shall be mailed first class unless otherwise directed by the State. The actual postage cost shall be a pass-through item and shall be billed on a monthly basis to the State in addition to regular invoices and shall include substantiating documentation. Printing and supply costs are to be included in the base rate of this Contract. The Contractor shall not invoice the State for Contractor business operations.

A.58.j. Contractor Communication with CoverRx PBM Program Enrollees. The Contractor shall comply with all requirements contained herein relating to communications with CoverRx enrollees.

1. CoverRx Member Materials. The Contractor shall comply with all requirements of this Contract, including but not limited to, Section A.8, relating to the approval and distribution of CoverRx Member Materials.
2. CoverRx Notices. In addition to the communications requirements set forth in Section A.8, the Contractor shall comply with the following provisions:
 - a. The Contractor shall be required to send welcome packets to enrollees. The Contractor shall have approval to subcontract the notice process as defined herein with the requisite approval from the State, but in no event shall off shore vendors be utilized.

- b. CoverRx Returned Mail. The Contractor shall track returned mail and shall report monthly, in a format to be determined by the State, to the State the number of pieces of returned mail, the reason the mail was returned and action taken by the Contractor. Included in this report shall be a list of all enrollees whose mail was undeliverable due to an incorrect address provided by the State. The Contractor shall have the right to subcontract this requirement after approval by the State.

A.58.k. CoverRx Provider Education

1. The Contractor shall develop and implement ongoing educational programs for the CoverRx provider community designed to improve provider awareness of CoverRx pharmacy program policies and procedures. These educational initiatives shall include, but not be limited to: provider letters, CDL distribution, POS messaging, training sessions, website postings of the CDL and other educational materials for prescribers. Prior to the CoverRx Go-Live date the Contractor shall conduct educational meetings for providers in East Tennessee, Middle Tennessee, and West Tennessee. In each calendar year during the term of this Contract, the Contractor shall exhibit at Tennessee Pharmacist Association (TPA) and Tennessee Medical Association (TMA) meetings with an informational booth, and at The University of Tennessee's Spring Pharmacy Update meetings in all locations. The Contractor shall develop notification and education strategies for CoverRx providers. Educational topics for prescribers shall include, at a minimum: CDL program intent; the process that was used to develop the CoverRx CDL and; how to access and use the CDL.
2. Upon State approval, the Contractor shall develop and produce program material to be provided to the State for distribution and supplied directly by the Provider Educator to provider groups.
3. The Contractor shall implement the agreed upon communication strategies through direct involvement with prescribers and pharmacy providers and a combination of site visits, telephone support, internet-based application, and direct mail.
4. The Contractor shall develop a process or system to capture the activities of the field-based Provider Liaison Pharmacists. On a calendar quarterly basis, the Contractor shall summarize, review and offer recommendations to the State regarding provider education.

A.59. CoverRx Pharmacy Call Center/Help Desk

- A.59.a. The Contractor shall operate a technical Pharmacy Call Center/Help Desk with the capability to promptly respond to systems and claims submission inquiries from pharmacies providing services to CoverRx recipients. The hours of operation shall be twenty four (24) hours per day and seven (7) days per week. Pharmacy inquiries arising from eligibility, benefit and Pro-DUR edits shall be resolved by this unit. The Call Center/Help Desk shall also function as a recipient customer service unit after hours and on weekends and holidays. In no event should the Call Center/Help Desk be in an off shore location.
- A.59.b. The Contractor shall install, operate, monitor and support an automated call distribution system that has capability to provide messaging regarding time to live agent pick up, tele-FAQs and fax-on-demand. The contractor's system shall record all calls in a digital format. The Contractor shall allow State staff to monitor calls in real-time and hear specific calls made to the Call Center/Help Desk if the State provides the date, time or callers number.
- A.59.c. The Contractor shall install, operate, monitor and support a contact management system that has capability to provide the management and on request reporting needs of the CoverRx Program.
- A.59.d. The Contractor shall provide sufficient staff, facilities, and technology to maintain service level within the Technical Help Desk such that calls are answered within thirty (30) seconds on at

least twenty-seven (27) days per month, and the abandoned calls shall not exceed two percent (2%) on more than three (3) days per month.

- A.59.e. All Call Center/Help Desk inquiries that require a call back shall be returned within one (1) business day of receipt one hundred percent (100%) of the time.
- A.59.f. The Call Center/Help Desk shall have efficient escalation process with a pharmacist onsite at all times.
- A.60. CoverRx Pharmacy Network Overview
- A.60.a. The Contractor shall establish and maintain a statewide pharmacy provider network of retail pharmacies adequate to provide pharmaceutical services and pharmacy location sites available and accessible in accordance with the provider network requirements as set forth by the State. Other than those addressed in this Contract, the Contractor shall not collect any additional fees, rebates, premiums or revenue from processing CoverRx claims.
- A.60.b. Retail pharmacies who offer to mail prescriptions as part of their business may be included in the network, subject to quantity limits of the CoverRx benefit. In addition, the Contractor shall provide to members a mail-order pharmacy option capable of processing member prescription volume. Contractor shall provide a toll-free telephone number to the pharmacy mail-order program and include information about accessing the mail-order program in the member welcome letter.
- A.60.c. CoverRx Access to Services. The Contractor shall maintain a network of pharmacy providers with a sufficient number of pharmacy providers who accept CoverRx enrollees within each geographical location in the state so travel times and distances do not exceed the allotted standard for a particular location as established in Contract Section A.60.d. The Contractor shall make services available twenty four (24) hours a day, seven (7) days a week, when medically necessary. The Contractor shall consider the following:
1. The anticipated need to have a prescription filled outside the service area;
 2. The expected utilization of services, taking into consideration the pharmaceutical needs of specific CoverRx populations represented in the PBM;
 3. The numbers and types (in terms of training, experience, and specialization) of pharmacy providers required to furnish the contracted CoverRx services;
 4. The geographic location of pharmacy providers and CoverRx enrollees, considering distance, travel time, the means of transportation ordinarily used by CoverRx enrollees, and whether the location provides physical access for CoverRx enrollees with disabilities.
 5. The Contractor shall ensure that network pharmacy providers offer hours of operation to CoverRx enrollees that are no less than the hours of operation offered to commercial enrollees.
 6. All completed, fillable, mail-order pharmacy prescriptions must be dispensed with a maximum turnaround time of forty-eight (48) hours.
- A.60.d. CoverRx Network Access. The Contractor shall maintain under contract a network of pharmacy providers to provide the covered services such that in:
- i. Urban areas transport access is at least three (3) miles travel distance and at least fifteen (15) minutes travel time as measured by the GeoNetworks® Accessibility Overview Analysis or such other software program as the State may specify;

- ii. Suburban areas transport access is at least ten (10) miles travel distance and at least twenty (20) minutes travel time as measured by the GeoNetworks® Accessibility Overview Analysis or such other software program as the State may specify; and
- iii. Rural/Frontier areas transport access is at least twenty-five (25) miles travel distance and at least thirty (30) minutes travel time as measured by the GeoNetworks® Accessibility Overview Analysis or such other software program as the State may specify.
- iv. Exceptions shall be justified and documented to the State on the basis of community standards. When requested by the State, the Contractor shall make arrangements to provide pharmacy services to enrollees residing in locations where a suitable network provider is not available.

A.60.e. CoverRx Monthly Provider Enrollment File. The Contractor shall submit a Provider Enrollment File that includes information on all providers of CoverRx pharmacy services upon request by the State. The Contractor shall submit this report in the format agreed to by the State. The Contractor shall submit this report within five (5) days of the request, or as otherwise provided by the State. Each Provider Enrollment File shall include information on all providers of CoverRx pharmacy services and shall provide a complete replacement for any previous Provider Enrollment File submission. Any changes in a provider's contract status from the previous submission shall be indicated in the file generated.

A.60.f. CoverRx Provider Directory. The Contractor shall be required to produce a provider directory that complies with Section A.8 and that shall be made available on the State's CoverRx's website.

A.60.g. CoverRx Pharmacy Audit.

1. The Contractor shall establish and maintain a Program Integrity process. The process shall detect and prevent errors, fraud or abusive pharmacy utilization by enrollees, pharmacies or prescribers. Pharmacies with aberrant claims or trends shall be contacted by the Contractor's staff to gain an acceptable explanation for the finding or to submit a corrected claim. The Contractor shall develop a trend or log of aberrations that shall be shared with the State. Each quarter the Contractor shall summarize findings from the reports and meet with the State to address program revisions. Revisions to the desk audit reports and review process shall be provided at no cost to the State. Program Integrity activities shall be summarized and reported to the State as described in this Contract. This section in no way limits or circumscribes, or supplants the requirements established in Sections A.23, A.24, and A.25 of this Contract.
2. The State shall request that the Contractor initiate a field audit when desk audits consistently identify aberrations that cannot be explained by other means or upon requests from legal authorities or regulatory agencies. The objective of the field audit shall include financial recovery, and elimination of the aberrant practice. The Contractor shall have the qualified staff available to conduct field audits or have an agreement with a vendor acceptable to the State within ninety (90) days of the date the Contractor assumes full responsibility for the CoverRx Program.

A.61. CoverRx Reporting Requirements

The Contractor shall submit accurate and complete reports to the State as described through this Contract. Reports shall meet the content, format and method of delivery requirements of the State. The State requires that all management reports be provided in accordance with the time frames set forth in the Performance and Deliverables section in Attachment G. All reports, analyses, and/or publications developed under this Contract shall be the property of the State. The State reserves the right to change reporting requirements and request ORRs

reports. All reporting shall be delivered through a web-based report library that can be imported to Microsoft Excel, CoverRx's Team Tracks, or formatted as tab- or comma-delimited text files if requested by the State.

A.61.a CoverRx Management Reports. The Contractor shall provide the State with industry standard utilization and financial management reporting. The Contractor's management reports shall provide a summary of drug costs by therapeutic category, by top ranked drugs, and by benefit categories. Reports shall include, but not be limited to:

1. Financial summary with change trend;
2. Utilization statistics;
3. Claim processing volume, processing time and other statistics to be reviewed by Contractor daily (abnormalities to be reported to the State immediately);
4. Pharmacy Drug Spend by category and also by drug; to be reported monthly;
5. Quarterly Net Cost trend reports, including Rebate data by drug, with details included on multiple worksheets to drill down to all drugs and categories;
6. Call Center metrics to be reviewed by Contractor daily (abnormalities to be reported to the State);
7. Rebate reports to be reviewed by Contractor weekly and then presented to the State at bi-annual clinical meetings (abnormalities to be reported to the State immediately); and
8. All other reports referenced in this Contract.

A.61.b. CoverRx Additional Capabilities and Custom Reports. In addition to standard management reports, the Contractor shall provide the following additional capabilities and custom reports in a format agreed to by the State.

1. CoverRx On Request Reports (ORRs). The Contractor shall be able to provide, at no extra cost to the State, ORRs that shall assist in managing the pharmacy benefit for CoverRx members. ORRs shall be provided in a format agreed to by the State and on a reasonable timetable.
2. CoverRx Decision Support Tools. The Contractor shall also furnish State staff with access to the Contractor's Data Warehouse allowing the State to retrieve raw paid, rejected and reversed claims data, along with a user interface that shall allow user defined queries to address managerial concerns that would normally be requested in an ORR. The capability shall not diminish the Contractor's responsibility for responding to requests for ORRs. Contractor shall be responsible to offer assistance to State staff using Contractor's Data Warehouse as needed, including both pharmacy staff and other departmental staff's users.
3. CoverRx Staff Online and Remote Access. The Contractor shall provide State and federal auditors, State staff and their designees, individual access to the Contractor's POS claims system, decision support system and other information systems as necessary via an online, real time connection at no additional cost to the State.
4. CoverRx Help Desk and Call Center Activity Reports. The Contractor shall produce reports on usage of the Help Desk and Call Center services, including numbers of inquiries, types of inquiries, and timeliness of responses.
5. CoverRx Help Desk Reporting. The Help Desk Call Center reporting shall be provided on a monthly basis, and at a minimum, shall include the following:

- (a) Total hours of daily Call Center access provided, and any downtime experienced;
- (b) Call abandonment rate, and average abandon time by day;
- (c) Average answer speed in seconds by day;
- (d) Average ACD time of calls handled by day;
- (e) Average wait time per caller;
- (f) Number of calls answered daily, and
- (g) Number of calls transferred to the State.

A.61.c. CoverRx Member Satisfaction Reports. If requested by TennCare, the Contractor shall conduct periodic surveys of member satisfaction with its services.

- 1. The surveys include content on perceived problems in the quality, availability, and accessibility of care.
- 2. As a result of the surveys, the Contractor:
 - (a) identifies and investigates sources of dissatisfaction;
 - (b) outlines action steps to follow up on the findings, and
 - (c) informs providers of assessment results.
- 3. The Contractor reevaluates the effects of the above activities.

A. 61.d. CoverRx Program Integrity Reports

- 1. CoverRx Ingredient Cost/Prescription Report. This report shall be generated when a total prescription cost exceeds Two Thousand Dollars (\$2,000.00) at retail. The claims must be reviewed by Contractor's clinical pharmacists for reasonableness, and reported to the State when/if abnormal results occur. Report to be used to identify incorrect claims submission.
- 2. CoverRx Override Report. Daily claims paid with unique adjudication rule reporting, as defined by the State, as requested by the State.
- 3. CoverRx Pharmacy Claim Reversals Report. The report shall identify pharmacies for which claim reversals may have manipulated payment by excessive reversals or failure to issue credits, and shall include pharmacies whose reversals total greater the three (3) percent or less than one percent (1%) of the total submitted prescription claims in a period. The report shall be produced as circumstances warrant.

A.61.e. CoverRx Reports for Other State Agencies. The State, at its discretion, may choose to delegate oversight of portions of this contract to other agencies. The Contractor shall be required to produce reports for other state agencies in a manner consistent with the terms of this Contract.

A.62. CoverRx Program Performance Guarantee.

Pursuant to Contract Section A.39, the Performance Metrics listed below have been selected by the State for the CoverRx Program, to take effect following CoverRx Go Live pursuant to a Control Memorandum to be issued by the State. Using these Performance Metrics, the following illustration shows hypothetical results for Contractor's services for one (1) month, including the Performance Metrics Pass/Fail Score, determination of the percentage of CoverRx Administrative Fee that will not be paid to Contractor for this month and total amount of CoverRx Administrative Fee that will be paid to Contractor for this month. The Pass/Fail Scores and all figures shown below are for illustration purposes only and shall not be deemed to revise or amend any provisions of this Contract.

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	Performance Metric	Pass/Fail Criteria	Pass/Fail Score
1.	Eligibility Determination and Application Processing	Attachment G, Table 2, Item 1	Pass
2.	Enrollment Determination Letters and Communication Materials	Attachment G, Table 2, Item 2	Pass
3.	Call Center/Help Desk Processing	If either of the metrics below are not met, the Pass/Fail Score shall be a Fail for the month	Fail
	3.a Call response time	Attachment G, Table 2, Item 3	(Pass)
	3.b Call abandonment rate	Attachment G, Table 2, Item 4	(Fail)
4.	Reporting	If any of the metrics below are not met, the Pass/Fail Score shall be a Fail for the month	Pass
	4.a. Required Reports	Attachment G, Table 2, Item 5	(Pass)
	4.b. Contractor Data Warehouse	Attachment G, Table 2, Item 6	(Pass)
	4.c. Ad hoc/ORR Reports	Attachment G, Table 2, Item 7	(Pass)

Performance Guarantee Payment Calculation – Per Contract Section C.3, up to twenty percent (20%) of Contractor's total monthly CoverRx Administrative Fee shall, as applicable, be reduced by the percentage that reflects Contractor's Performance Metrics Pass/Fail Score for the month. The total amount of CoverRx Administrative Fee to be paid to Contractor for this month in the above illustration is based on Contractor having passed three (3) of the metrics and failed one (1) metric and is determined according to the following calculation:

Step 1. Determination of percentage of CoverRx Administrative Fee that will not be paid to Contractor for this month:

Number of Performance Metrics failed	1	2	3	4
Percentage deducted from monthly CoverRx Administrative Fee Payment	5%	10%	15%	20%

Step 2. Determination of amount of CoverRx Administrative Fee that will be paid to Contractor for this month:

Full amount of monthly CoverRx Administrative Fee - 5% = total amount of monthly CoverRx Administrative Fee to be paid to Contractor

CoverKids Pharmacy Services

A.63. CoverKids Services Implementation Plan.

A.63.a. At the sole discretion of the State, the State may work with the Contractor to modify or simplify the CoverKids Services Implementation Plan described below.

A.63.b. CoverKids Services Implementation Plan Overview. Implementation of the CoverKids portion of this Contract shall be conducted as series of defined phases described below, with the date on which the Contractor is to assume full responsibility for operation of CoverKids PBM scheduled to be January 1, 2020. The Contractor shall be required to complete all the tasks, obligations and responsibilities listed under each phase by the dates identified in the CoverKids Project Plan which shall be developed by the Contractor and an implementation contractor procured by the State (Implementation Contractor) and submitted to the State for review and approval. The CoverKids Project Plan shall be prepared using Microsoft Project, or such other program as the State may direct, and shall include a detailed timeline description of all work to be performed both by the Contractor, Implementation Contractor and TennCare. The CoverKids Project Plan shall also include a description of the participants on the Contractor's, Implementation Contractor's and TennCare' transition teams and their roles and schedules of meetings.

A.64. CoverKids Ambulatory/Specialty Pharmacy Services Implementation Plan and Readiness Review Schedule. At the appropriate time, as determined by the State, a Control Directive will be sent to the Contractor requesting the Contractor to submit a CoverKids Ambulatory and Specialty Pharmacy PBM Services Implementation Plan and Readiness Review Plan (CoverKids Ambulatory/Specialty Pharmacy Services Implementation/Readiness Plan) containing all necessary deliverables and activities for these services with projected dates for delivery and/or completion of these items. Upon approval of the CoverKids Project Plan by the State, TennCare will direct the Contractor to begin work on the CoverKids Ambulatory/Specialty Pharmacy Services Implementation/Readiness Plan through a Control Memorandum and Control Directive in which all deliverable and activity due dates match the dates in the approved CoverKids Project Plan. The State reserves the right to further revise the due dates for the CoverKids Ambulatory/Specialty Pharmacy Services Implementation/Readiness Plan deliverables and activities and to add additional deliverables and activities, as deemed necessary in the State's sole discretion to be in the best interest of the CoverKids Program. Time is of the essence in the satisfactory completion of all CoverKids Ambulatory/Specialty Pharmacy Services Implementation/Readiness Plan deliverables and activities by the due dates contained in the revised State approved CoverKids Project Plan.

A.65. CoverKids Project Initiation and Requirements Definition Phase.

A.65.a. The State shall conduct a project kick-off meeting. All key Contractor project staff shall attend. TennCare project staff shall provide access and orientation to the CoverKids Pharmacy Program and system documentation. TennCare technical staff shall provide an overview of the Tennessee Medicaid Management Information System (MMIS) emphasizing pharmacy claims processing and adjudication, reference files, and payment processes.

A.65.b. During this phase the Contractor shall develop the documentation identified below and submit it to the State for review and approval in accordance with the CoverKids Services Implementation Plan Schedule:

1. Functional and Informational Requirements (FIR) Document. This document shall include detailed requirements for both internal and external interfaces and all CoverKids Point-of-Sale (POS) functionalities required by the RFP and/or contained in the Contractor's proposal and/or this Contract. Eligibility interfaces with TennCare are critical and the Contractor must be in sync with the MMIS eligibility data. All outbound 834 Files from TennCare must be loaded to the Contractors data base within twenty-four (24) hours of receipt from. This requirement includes any 834 Transactions that must be handled manually by the Contractor. In preparation for CoverKids Go Live, the Contractor shall be required to receive the base CoverKids population via an 834 File on or before December 1, 2019. On and after the initial CoverKids eligibility is loaded, the Contractor will receive daily 834 Transactions for new, termed and changes for the CoverKids population.

2. Data Dictionary. For each data field this shall indicate content, size, values, structure, edit criteria and purpose.
3. Data Mapping. This shall consist of a cross-reference map of required MMIS data and CoverKids POS data elements and data structures. A separate data structure map shall be required for each transaction and interface. A data conversion plan, that includes both automated and manual activities, shall be provided for each data structure map. TennCare shall make any necessary data formats available to the Contractor.
4. Suggested MMIS Modifications. The Contractor shall recommend any design modifications to the MMIS that it determines are suggested or necessary relating to the CoverKids PBM services. MMIS modification suggestions shall be communicated with reasonable advance notification to allow adequate assessment of the MMIS work effort. Performing any modifications, maintenance and design enhancements to MMIS shall be the sole decision and responsibility of TennCare.

A.66. CoverKids System Analysis/General Design Phase.

A.66.a. After approval of the documentation by TennCare required in the Project Initiation and Requirements Definition Phase, the Contractor shall develop the General System Design Document and submit it to the State for review and approval in accordance with the CoverKids Services Implementation Plan Schedule.

A.66.b. The General System Design Document shall include the following information:

1. An Operational Impact Analysis that details the procedures and infrastructure required to enable MMIS, the Contractor's system, and the "switch" systems used by pharmacy providers to work effectively together.
2. A Detailed Conversion Plan that specifies plans for conversion of fifteen (15) months of MMIS and the previous PBM contractor/processor's claims history, provider, recipient, preferred drug list, prior authorization, lock-in and reference data.
3. A Software Release Plan that sets forth the project's implementation into production. This document shall explain procedures for coordinating system changes that shall have an operational or information impact on CoverKids POS operations. It shall detail how CoverKids POS and/or MMIS software releases are tested and coordinated. The plan shall include both initial implementation of the CoverKids POS system and coordination of software releases between MMIS and CoverKids POS.

A.67. CoverKids Technical Design Phase.

A.67.a. During this phase, detailed specifications shall be developed for conversion and for the interface(s) between the MMIS and the Contractor's system.

A.67.b. The Contractor shall develop the documentation and plans identified below and submit them to the State for review and approval in accordance with the CoverKids Services Implementation Plan Schedule:

1. Preliminary System Interface Design Overview Document;
2. Unit Test Plan that includes test data, testing process, and expected results;
3. Back-up and Recovery Plan that includes processes for daily backup and recovery of system information;
4. Final Disaster Recovery Plan;

5. Information Security Plan that includes how the Contractor shall maintain confidentiality of CoverKids data. This document shall include a comprehensive Risk Analysis;
6. System, Integration, and Load and Test Plan; and
7. Final System Interface Design Overview Document to be completed after the Contractor has conducted a review of all previous design documents.

A.68. CoverKids Development Phase.

A.68.a. This phase includes activities that shall lead to the implementation of the CoverKids POS System. The Contractor shall develop interface and conversion programs, develop system documentation, and develop Unit Test Plans.

A.68.b. The Contractor shall conduct all testing in accordance with the CoverKids Services Implementation Plan Schedule. Where manual data entry screens are required, the Contractor shall develop these screens.

A.68.c. The Contractor shall perform testing on all phases and programs shall be documented.

A.68.d. System testing shall require reports to substantiate and document the testing. These reports shall include:

1. number of tests run,
2. number of requirements tested,
3. number of tests passed,
4. number of tests failed, and
5. number of tests retested after initial failure.

A.68.e. The Contractor must maintain an issues log which details any testing failures and includes the resolution for those issues. During final User Acceptance Testing (UAT) with TennCare, only TennCare can approve the Contractor's issue resolutions.

A.68.f. The Contractor shall perform testing activities that shall include the following:

1. CoverKids POS System Test to validate the appropriate adjudication of a claim which shall include a description of the test procedure, expected results, and actual results;
2. Integration Testing shall test external system impacts including provider POS systems, downstream MMIS applications, and all interfaces. It shall include a description of the test procedure, expected results, and actual results;
3. Load and Stress Testing shall include volume and efficiency to ensure that the system is able to process the volume of CoverKids pharmacy claims. It shall include a description of the test procedure, expected results, and actual results; and
4. Final User Acceptance Testing (UAT).

A.69. CoverKids Services Implementation/Operations Phase.

A.69.a. During this phase the Contractor, Implementation Contractor and TennCare shall assess the operational readiness of all required system components including, but not limited to, MMIS, the CoverKids POS, and required communications links with the pharmacy "switch" providers. This shall result in the establishment of the operational production environment in which all CoverKids pharmacy claims shall be accurately and reliably processed, adjudicated and paid. TennCare shall have final approval for all elements of the operational production environment. The Contractor shall coordinate with the Implementation Contractor to develop

the documentation and deliverables identified below and submit them to the State for review and approval in accordance with the TennCare Services Implementation Plan Schedule.

- A.69.b. The Contractor shall coordinate with the Implementation Contractor to develop the documentation and deliverables identified below and submit them to the State for review and approval in accordance with the CoverKids Services Implementation Plan Schedule. The Contractor shall not proceed to the subsequent phase without receiving said approval. The Contractor shall be responsible for timely submitting the following deliverables:
1. Operations Procedures shall be developed and prepared for all procedures and operations performed by Contractor, including but not be limited to, automated operations, data entry operations, Help Desk operations, prior authorization operations/interfaces, check and remittance fulfillment and member notifications;
 2. Production and Report Distribution Schedules shall be developed;
 3. Operations Training Plan shall be updated;
 4. Training Materials for TennCare staff, pharmacy providers, and other identified stakeholders shall be developed;
 5. Training Sessions shall be scheduled and the Contractor shall conduct training sessions for TennCare staff, pharmacy providers, and other identified stakeholders;
 6. A Final Conversion Plan shall be developed by Contractor. This plan shall, at a minimum, contain the following activities and projected dates on which each activity shall occur:
 - (a) Loading fifteen (15) months of claims history from TennCare's outgoing PBM Contractor's POS system into the Contractor's POS system;
 - (b) Migrating current prior authorizations, overrides and grandfather provisions with their end dates into the Contractor's POS system from TennCare's outgoing PBM Contractor's POS system; and
 - (c) Running other conversion programs, performing manual functions, performing quality control, reporting on outcomes, and converting files in preparation for CoverKids system operation.
 7. Final Conversion Activities shall be performed by Contractor pursuant to the approved Final Conversion Plan.

A.70. CoverKids Readiness Review.

A.70.a. The State may conduct an on-site review to assess the readiness of the Contractor to effectively administer and provide the services as defined in this Contract. The Contractor shall complete all implementation actions prior to "go-live" date and according to the implementation timeline provided by the Contractor to TennCare. The Contractor shall receive TennCare's sign-off that each action has been completed successfully.

A.70.b. Implementation action steps include the following minimum items:

1. Benefit plan designs loaded, operable and tested;

2. Perform comprehensive systems testing (including interface testing with all third parties) and quality assurance audits, with results reported to the TennCare prior to the "Go-Live";
3. Eligibility feed formats loaded and tested end to end;
4. Operable plan for transferring current Help Desk toll-free numbers from current TennCare PBM contractor to the Contractor;
5. Signed agreements for all providers in the CoverKids PBM Network;
6. Account management, Help Desk and Prior Authorization staff hired and trained;
7. Established billing/banking requirements;
8. Complete notifications to pharmacies and prescribers regarding contractor change;
9. Each component shall be met by an agreed upon deadline in an implementation timeline provided by Contractor to TennCare. Implementation action requirements may include other items necessary to meet the claims processing commencement date of January 1, 2020 at 12:01 A.M. CST, and
10. Claims history and existing prior authorizations and overrides shall be migrated to the Contractor's POS system.

A.71. Remedies Related to CoverKids Implementation Plan and Readiness Review Failure. The Contractor shall produce all required CoverKids Implementation Plan and Readiness Review deliverables and complete all activities by the due dates indicated on the CoverKids Implementation Plan Schedule, in a timely manner and to the satisfaction of the State. Failure to do so shall be considered a material breach of this Contract, and the State may initiate the Termination for Cause provisions located in Section D.6, or take such other actions and seek such other remedies as are available to it pursuant to this Contract, or at law, or in equity.

A.72. CoverKids Point-of-Sale (POS) System

A.72.a. CoverKids POS System Overview

1. The Contractor shall provide an online pharmacy POS system that can be modified to meet the needs of TennCare. The Contractor shall provide system design and modification, development, implementation and operation for the CoverKids-POS system. The Contractor's POS system shall allow it to interface with the existing pharmacy "switch" networks that connect the pharmacy providers with the Contractor's system.
2. The Contractor shall maintain a test environment that exactly mirrors the production environment. TennCare and its designees shall be granted access to this test environment for purposes of quality control and audit functions.
3. The Contractor shall be responsible for operating the provided system that automates the entire pharmacy claims processing system for the complete pharmacy benefit for all CoverKids enrollees.
4. The source of the claims shall be enrolled Network pharmacy providers. The majority of claims shall be submitted through point-of-sale telecommunications devices. However, the Contractor shall also process claims on batch electronic media for the Tennessee Department of Health's CoverKids pharmacy claims.

A.72.b. CoverKids Claim Adjudication Services - General Requirements

1. This section defines claim adjudication requirements for all CoverKids pharmacy claims regardless of source and including electronic batch and POS claims. The timing of the adjudication shall differentiate POS claims from claims submitted in batch. However, all claims shall be adjudicated through a common set of processing modules. All claims adjudicated as payable shall be for eligible members to enrolled or appropriate providers for approved services and in accordance with the payment rules and other policies of TennCare. All adjudicated claims shall be captured to an encounter file and transferred weekly to the TennCare MMIS by the Contractor. The National Council for Prescription Drug Programs (NCPDP) Post Adjudication Standard 4.5 format shall be used for the encounter file. At the direction of TennCare, the Contractor shall make changes to data elements included on the encounter file with no additional cost to TennCare.
2. The Contractor shall distribute and mail CoverKids outputs (hard copy and electronic) as directed by TennCare, including but not limited to provider checks and remittance advices, returned claims, notices, provider bulletins, provider manuals and special mailings. The Contractor shall be responsible for system messages and notice of claims being adjudicated payable, denied or rejected. Claims denied or rejected shall return situation specific messages to assist pharmacies with resubmissions. All printing, supply and postage costs for checks and remittance advices shall be included in the Contractor's monthly Administrative Fee, and shall not be invoiced to the State.
3. Pass-Through Costs of Certain Mailings to CoverKids Enrollees. The Contractor shall use first class rate for returned claims, enrollee notices, provider bulletins, provider manuals and special mailings, unless otherwise directed by TennCare. Postage costs incurred by the Contractor for these mailings shall be treated as pass-through costs. Such costs shall be billed on a monthly basis to TennCare in addition to regular invoices and shall include substantiating documentation. Each batch shall have its own reconciliation and money remits. No overhead, administrative or other fee shall be added to such pass-through costs.
4. Contractor shall comply with the following requirements regarding CoverKids Claims Adjudication Services:
 - (a) Cash flow – For checks to be issued on Friday, the Contractor shall deliver the following two (2) files to the State, or its designees, in an electronic media suitable to the State, by 10:00 a.m. Central Standard Time, on Tuesday of each week:
 - (1) All transactions, (i.e., claims, financial adjustment, etc.) identified by MCO, that comprise the payments to be issued for Friday of that week. In cases of holidays the Contractor shall notify pharmacy providers if a schedule change is to occur at least two (2) weeks in advance and issue checks and remittance advices within two (2) business days of the routine date.
 - (2) All payments, (check register) identified by MCO, to be made on Friday of that week. TennCare shall be notified no later than one (1) business day of any systems or operational issues that may impact disbursements by the prescribed time lines. The file described in (i) above shall contain all transactions that make up the payments in the file described.
 - (b) The Contractor shall mail checks and remittance advices for claims that were submitted through its CoverKids POS system for that work week on Friday of each week, with the exception of weeks during which the State is officially closed due to a holiday or for any other reason (Holiday Weeks). In the case

of Holiday Weeks, the Contractor shall notify pharmacy providers if a schedule change for mailing checks and remittance advices is to occur at least two (2) weeks in advance and shall issue checks and remittance advices within two (2) business days of the date the Contractor would have issued the checks and remittance advices if it had not been a Holiday Week.

- (c) TennCare reserves the right to review the files prior to issuing payment and to hold or adjust any payment that is not satisfactory to the State. The Contractor is required to offer automatic deposit to its providers. If the Contractor submits a claims payment request and the State overpays the claim, the State reserves the right to withhold the overpaid monies. The Contractor shall be responsible for providing RAs to providers unless the provider elects not to receive hardcopy RAs. Remittance Advices shall be included in payments by the Contractor to providers. The Contractor shall comply with the American National Standards Institute Care Claims Payment and Remittances Advice Format known as the "ANSI 835". The ANSI 835 is a HIPAA compliant format. The Contractor shall be responsible for ensuring that any payments funded by CoverKids are accurate and in compliance with the terms of this Contract, agreements between the State or Contractor and providers, and state and federal laws and regulations.
- (d) The Contractor shall ensure that collection letters are sent to contracting pharmacies that maintain an accounts-payable balance to the State greater than ninety (90) days. These notices shall be sent within five (5) business days of becoming ninety (90) days old. The Contractor shall provide TennCare with a monthly report of notices sent, due within ten (10) business days after end of month of reporting period. Postage costs incurred by the Contractor shall be treated as pass-through costs. In addition to regular invoices, these costs shall be billed on a monthly basis to the State and shall include any necessary substantiating documentation. Printing and supply costs for collection mailings shall be included in the base rate of this Contract.
- (e) The Contractor shall provide TennCare's Fiscal Services Unit a report detailing all checks remitted to contracted pharmacies on behalf of the State that remain outstanding (that have not been cashed) more than ninety (90) days. Reports are due monthly on the fifteenth (15th) day of the month following the reporting period.
- (f) The Contractor shall have in place a POS claims processing system capable of accepting and processing claims submitted electronically. To the extent that the Contractor compensates providers on a fee for service or other basis requiring the submission of claims as a condition to payment, the Contractor shall electronically process the provider's claims for covered benefits provided to members consistent with applicable CoverKids policies and procedures and the terms of this Contract.
- (g) The Contractor shall, if appropriate, pay within fifteen (15) days of receipt one hundred percent (100%) of all clean claims submitted by Network and non-Network pharmacy providers through POS and batch electronic claims submission. The term "pay" means that the Contractor shall either send the provider cash or cash equivalent in full satisfaction of the clean claim, or give the provider a credit against any outstanding balance owed by that provider to the Contractor. The Contractor shall pay the clean claim or advise the provider that a submitted claim is: (1) a "denied claim" (specifying all reasons for denial); or, (2) an "incomplete claim" that cannot be denied or allowed due to insufficient information and/or documentation (specifying in detail all information and/or documentation that is needed from the provider in order to allow or deny the claim). An incomplete claim may be resubmitted with the

information necessary to complete the claim. This resubmission shall constitute a new claim only for the purpose of establishing a timeframe for claims processing.

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

A.72.c. CoverKids Claims Receipt and Management

1. The Contractor shall receive batch electronic and point of sale (POS) claims. The Contractor shall apply a unique identification number to each claim and any supporting documentation regardless of submission format. The identification number shall be used to recognize the claim for research or audit purposes. Control totals shall be utilized to ensure that all claims have been processed to completion. Appropriate safeguards shall be in place to protect the confidentiality of TennCare and enrollee information.
2. At the point of sale, the Contractor shall identify and deny claims that contain invalid provider numbers. This shall include cases where the number is missing, the check digit fails, or the provider number does not identify an entity to receive a Remittance Advice. Claims that contain these errors shall be returned to the originating provider. Pharmacy Providers shall submit claims and be identified by their individual and specific NPI (National Provider Identification) numbers. Prescribers shall be identified on all pharmacy claims by their specific NPI.
3. The Contractor shall identify and deny claims (unless specifically instructed differently by TennCare) that contain National Drug Code (NDC) numbers for which drug rebates under the Omnibus Budget Reconciliation Act (OBRA) of 1990 and subsequent amendments of OBRA in 1993, are not available, including non-covered drug codes, DESI, LTE and IRS drug codes and any terminated or obsolete drug codes. Such claims shall reject with situation specific messaging and error codes.
4. Unless a claim resolution is being managed by TennCare staff in accordance with TennCare guidelines or held by the Contractor under TennCare written directive, the Contractor shall be held to the following timeline requirements:
 - (a) POS Claims - The Contractor shall process ninety-nine and a half percent (99.5%) of POS claims on a daily basis within ten (10) seconds of receipt by the Contractor's processor. This is the time from when the claim is received by the Contractor's processor to the time the results are transmitted from the Contractor's processor and shall include all procedures required to complete claim adjudication. The Contractor shall notify TennCare within one hour (1) of sub-standard system performance.
 - (b) Batch Electronic Media Claims (EMC) - The Contractor shall receive claims in electronic format, via batch transmission. All batch claims should be scheduled for immediate processing. The Contractor shall assign identification control numbers to all batch claims within twenty-four (24) hours

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

5. The Contractor's system shall operate without unscheduled or unapproved downtime. The Contractor shall report to TennCare immediately (within one (1) hour) upon knowledge of unscheduled or unapproved downtime. A system down or "downtime" shall be defined as an interruption involving more than ten percent (10%) of production for a period greater than fifteen (15) minutes. The Contractor shall also provide TennCare updates at regular intervals during a sustained downtime. TennCare shall be presented with recovery options as appropriate. Upon full system recovery, the Contractor shall provide TennCare with a System Downtime Analysis describing root cause issues and actions to mitigate future downtime occurrences within five (5) business days after full system recovery.
6. The Contractor shall ensure that collection letters are sent to contracting pharmacies that maintain an accounts-payable balance to the State greater than ninety (90) days. These notices shall be sent within five (5) business days of becoming ninety (90) days old. The Contractor shall provide TennCare with a monthly report of notices sent, due within ten (10) business days after end of month of reporting period. Postage costs incurred by the Contractor shall be treated as pass-through costs. In addition to regular invoices, these costs shall be billed on a monthly basis to the State and shall include any necessary substantiating documentation. Printing and supply costs for collection mailings shall be included in the base rate of this Contract.
7. The Contractor shall provide TennCare Fiscal Services Unit a report detailing all checks remitted to contracted pharmacies on behalf of the State that remain outstanding (that have not been cashed) more than ninety (90) days. Reports are due monthly on the fifteenth (15th) day of the month following the reporting period.
8. CoverKids Help Desk for System Support - The Contractor shall maintain toll-free telephone access to support system operations. The Help Desk shall be staffed by a clinical pharmacist who shall be physically on duty (not on call) twenty-four (24) hours a day, seven (7) days a week to respond to questions and problems from providers regarding system operations and claims inquiries. The Contractor shall supply all the required information systems, telecommunications, and personnel to perform these operations. In no event should the Contractor use off shore sites for any area of performance of this Contract.

A.72.d. CoverKids Data Validation Edits and Audits

1. The system shall screen all claims and apply all TennCare-approved and required data validation procedures and edits. Consistency controls shall be in place to ensure that dates, types, and number of services are reasonable and comply with CoverKids policy and/or rules. These control measures may be changed by TennCare at no cost.
2. The Contractor shall notify TennCare in writing of any and all claims that have been erroneously processed in accordance with Contract Section A.33. The Contractor shall initiate appropriate action to correct the errors, such as but not limited to adjustments and recoveries within twenty-four (24) hours of discovery. Incorrect claims include, but are not limited to: claims paid for ineligible members; claims paid to a terminated provider; claims paid for duplicate services; claims paid for a non-covered service; and claims paid at an incorrect rate or claims that denied or rejected inappropriately. In addition to the requirements of Contract Section A.33, the

Contractor shall follow-up such notification to TennCare by letter and provide a report documenting all claims paid resulting from any system errors that resulted in provider overpayment or other incorrect payment. The Contractor shall reimburse TennCare for the cost of all claims paid as a result of Contractor error. Reimbursement or damages resulting from this Section may be applied as offsets to future administrative fees.

3. Using an industry-accepted standard, the Contractor shall define the categories of data elements such as brand/generic/non-preferred brand classification, and therapeutic categories. The Contractor's system shall permit TennCare to override these values using its own policies/procedures.
4. The Contractor shall establish a system capable of adding, changing, or removing claim adjudication processing rules. At no cost to TennCare, the Contractor shall add, change, or remove claim adjudication rules in its system to accommodate changes that the State determines, in its sole discretion, to be necessary or required. At installation, the system shall be able to perform the following validation edits and audits, which TennCare shall have the ability to and shall have the right to override at its discretion.
5. TennCare reserves the right to override any system edit whenever it deems appropriate and necessary.
6. CoverKids Prior Authorization - The system shall determine whether a prescribed drug requires prior authorization, and if so, whether approval was granted prior to dispensing the prescribed drug and reimbursement to the provider.
7. CoverKids Supplemental Messaging - The Contractor's CoverKids-POS system shall be capable of customizing supplemental messages in lieu of standard denial codes, to contain alternative therapies listed on the CoverKids formulary.
8. CoverKids Valid Dates of Service - The system shall ensure that dates of services are valid dates, are no older than one hundred eighty (180) days from the date of the prescription (unless approved by TennCare) and are dates that have already occurred (not dates in the future).
9. CoverKids Duplicate Claims - The system shall automatically inform the provider that the current claim is an exact or possible duplicate and deny that claim as appropriate.
10. CoverKids Prescription Validity - The system shall ensure that the time period for a prescription has not expired and that the number of valid refills has not been exceeded.
11. CoverKids Covered Drugs - Unless otherwise directed by TennCare, the system shall verify that a drug code (NDC) is valid and the drug is eligible for payment under the CoverKids pharmacy program and eligible for drug rebates. OTC drugs shall only be covered to the extent that they are prescribed by a health care provider legally qualified to write prescriptions. The Contractor shall have appropriate processes in place to assure that OTC drugs are only reimbursed as described above, or in another manner as described by TennCare.
12. CoverKids Compounded Drugs - The system shall capture, edit, and adjudicate pharmacy claims as necessary to support CoverKids compounded drug prescription coding policy and/or rules. All system edits that are in place for non-compounded prescriptions shall be in place and active for compounded prescriptions (e.g. prior authorization).
13. CoverKids Provider Validation

- (a) The system shall approve payment only for claims received from providers who are eligible to provide pharmacy services, and for CoverKids and non-CoverKids providers who are authorized (as required by TennCare) to prescribe pharmaceuticals. The system shall be populated with current, updated pharmacy and prescriber provider location and contact information.
- (b) The system shall be capable of customizing prescriber networks upon TennCare's request, and accepting prescriber provider files from TennCare in a mutually agreed upon format. The system shall have the capability to determine whether the prescriber is a Network provider, and reject claims based on the provider's Network status, if requested by TennCare. The system shall also have the capability to report on claims (both paid and rejected) based on provider status, whether in-Network or out-of-Network.

14. CoverKids Recipient Validation

- (a) A Valid Claim is a claim for service for those members eligible to receive pharmacy services at the time the services were rendered. The system shall approve only these Valid Claims.
- (b) TennCare shall transmit eligibility/enrollment information to the Contractor by the standard HIPAA compliant 834 Transaction as defined by the TennCare Companion Guide. TennCare shall be responsible for assuring that the eligibility file provided is accurate and complete. The Contractor shall use this information to immediately (within one (1) business day) identify individuals whose enrollment status has changed, update the eligibility information in the Contractor's data system, and take appropriate action as outlined below.
- (c) The NCPDP Post Adjudication Standard 3.0 format shall be used for encounter reporting sent to TennCare.
- (d) If the Contractor has been billed for any claims for a recipient who was deceased at the time the service was allegedly provided or who is no longer eligible for CoverKids, then the Contractor shall be required to recoup monies paid to any provider that had knowledge of, or should have had knowledge of the recipient's death and to repay any monies collected by the Contractor for the claims that were paid post date of death or post eligibility for enrollment. On a monthly basis, the Contractor shall report the amount recouped by the Contractor and the amount to be repaid to TennCare. In addition, the Contractor shall reimburse TennCare monthly for monies owed to TennCare as a result of billing for recipients not eligible to receive services.

15. CoverKids Quantity of Service - The system shall validate claims to ensure that the quantity of services is consistent with CoverKids policy and/or rules (i.e., verify that drug specific minimum and maximum quantity limitations, as well as days' supply, if imposed, are followed as described by TennCare). The system shall have the capability to accumulate total quantities and/or equivalent dosing across different drugs within therapeutic categories (i.e. calculation of Morphine Equivalent Daily Dose).

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

17. CoverKids Managed Care Organizations - Contractor shall identify products that should be administered as a medical benefit. The system shall reject claims that are required to be processed and paid by a member's MCO for any and all medical benefits (when that MCO is responsible for those claims). A list of identified drugs shall be generated, published and updated quarterly by the contractor. Contractor

shall assist the State in identifying new and existing products that should not be considered as pharmacy claims based on Contractor's experience with other State's programs. Once identified, a list of drugs shall be created, published and updated quarterly by the contractor.

18. CoverKids Early Refills - The systems shall be able to recognize when an enrollee attempts to refill a prescription (either the original prescription or a new prescription for the same drug) and require that ninety-five percent (95%) for controlled products and eighty-five percent (85%) for non-controlled products or any other percentage threshold as directed by TennCare, of the original days' supply has passed since the original filling. Overrides at the pharmacy level shall be permitted by the Contractor's Help Desk for drug categories as directed by TennCare, but monthly reports shall identify the enrollee and the pharmacy provider where such overrides occurred.
19. Tiered Co-pay Edit - A tiered co-pay structure shall be coded into the POS system. Initially, only three (3) tiers may be established. At a later date, a more complex structure may be required by TennCare without any additional cost to TennCare. Contractor's system shall accommodate tiered co-pay structures as defined by TennCare including but not limited to brand vs. generic or preferred vs. non-preferred products.
20. CoverKids Usual and Customary (U&C) Edit – Reimbursement logic shall compare the sum of the ingredient cost and dispensing fee to the submitted U&C amount and pay the less amount.
21. CoverKids Maximum Dollar Amount Edit – All pharmacy claims over a specified dollar amount per claim shall reject at the POS and the pharmacy provider shall be required to call the Contractor Call Center regarding rejected claims. This includes a two hundred fifty dollar (\$250) limit on compounded claims (including intravenous compounds), a one thousand five hundred dollar (\$1,500) limit on non-compounded, non-exception claims, and a forty thousand dollar (\$40,000) limit on exception claims (blood factors and other identified products). Contractor shall monitor claims that trigger the Maximum Dollar Amount. The Contractor's system shall be capable of adding, changing, or removing maximum dollar edit rules at no cost to TennCare when requested by TennCare.
22. CoverKids Prescriber Number Edit - The POS claims processing system shall be configured to require that all claims shall be submitted with the prescriber's NPI number. The validity of NPI numbers shall be determined by the most current data available from the CMS Plan and Provider Enumeration System (NPPES).
23. CoverKids Unit of Measure Edit - The Unit of Measure (UOM) edit shall perform two (2) main functions:
 - (a) Check incoming claim units (i.e., gram, milliliter, etc.) versus the units listed in Reporting System for that particular NDC; and
 - (b) Verify that the unit amounts transmitted is consistent with the unit amounts in Reporting System. The submitted quantity shall be a multiple of the unit size shown in Reporting System (i.e., claim shall be rejected if unit amount transmitted has been rounded). For example, the units transmitted is fourteen (14), but the unit amount is thirteen point seven (13.7) in the Reporting System.
24. CoverKids Prescriber Last Name Edit - The claims processing system shall be set to ensure that the submitting prescriber's last name correctly matches the last name associated with the NPI number.

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

25. CoverKids Third Party Liability/Coordination of Benefits. The Contractor shall be responsible to ensure that CoverKids is the payor of last resort in all situations where an enrollee has other health insurance coverage (Other Insurance), and to ensure that all COB (Coordination of Benefits) claims are being adjudicated only when Other Insurance has been exhausted first. The Contractor shall obtain current information regarding enrollees' Other Insurance in addition to CoverKids, and perform daily updates to a third party liability (TPL) file. The TPL file shall then be used to enable the point of service (POS) system to validate claims to determine whether there is a liable third party.

In situations where Other Insurance coverage is detected for the date of service, an edit shall be generated at the POS prompting the pharmacy to transmit the claim to the Other Insurance prior to transmitting the claim to the CoverKids pharmacy benefit. The following information shall be included in the POS messaging, when available: Phone number for the primary Other Insurance, Bank Identification Number (BIN), Processor Control Number (PCN), Group Number, and Cardholder ID. The POS system shall be able to adjudicate claims where there may be more than one (1) liable Other Insurance. In the event that the amount paid by the Other Insurance(s) exceeds TennCare's maximum allowable, then the claim shall return a paid amount of zero (\$0.00) through TennCare.

In addition, the system shall allow pharmacies to override the TPL edit at the POS level with the use of National Council for Prescription Drug Programs (NCPDP) standard Other Coverage Code (OCC) overrides. The Contractor shall provide pharmacy assistance with TPL edits/coordination of benefits (including use of OCC overrides) through the Technical Pharmacy Help Desk (described in Section A.78 of this Contract).

- A. The State reserves the right to require the Contractor to use a TPL file provided by the State. Should the State require Contractor to use the State's TPL file, the State will be responsible for providing an updated TPL file to the Contractor on a regular basis, which will include all known beneficiaries with active Medicaid eligibility and active prescription benefit coverage with another payor, including both commercial coverage and Medicare Part D coverage. The layout of the file shall include the following key elements at a minimum to ensure the Contractor has the necessary data to coordinate Other Insurance at the POS:

- a. Recipient Medicaid ID
- b. Recipient Last Name
- c. Recipient First Name
- d. TennCare Carrier Code
- e. Carrier Name
- f. Carrier Address
- g. Carrier Group Number
- h. Policy ID
- i. Effective Date
- j. End Date
- k. Coverage Code

TennCare will work with the Contractor on a method to transfer this file and confirm receipt.

- B. Should the State not require the Contractor to use the State-provided TPL file, Contractor shall provide the TPL file utilized by the Contractor to TennCare on a monthly basis in a format approved by the State. The layout of the file shall include at a minimum, the key elements in Contract Section A.72.d.25.A above. TennCare will work with the Contractor on a method to transfer this file and confirm receipt.
 - C. TPL Audit. To ensure that the Contractor correctly uses either the State-provided TPL file, or Contractor's file, the State shall request a third party vendor to conduct a monthly TPL audit of paid claims and claims denied solely with NCPDP Denial Codes "41" and "13". Audit will be performed by the third party vendor using the State-provided TPL file and Contractor's TPL file to ensure that all Other Insurance is exhausted before the State makes any payment on any claim. The Contractor shall provide the files as required by the third party vendor. All disputes between the Contractor and the third party vendor shall be resolved by the State at the State's sole discretion.
 - D. Pharmacy Provider Analysis. Contractor shall educate pharmacy providers regarding proper billing practices and carrier codes associated with NCPDP's current version. The Contractor and the Contractor's POS system shall strictly adhere to state and federal laws and regulations and State policy and/or rules regarding coordination of benefits and third party liability.
 - a. Contractor shall use reporting and other means of analyses to determine whether network pharmacy providers are making all efforts to use the information received in POS messaging with the denial to transmit the claim to the primary payor prior to transmitting to CoverKids.
 - b. Pharmacy providers that are found as outliers with high percentages of denied claims without a final claim paid by either the primary payor or by CoverKids shall be audited, and corrective action shall be taken if claims could have been paid by the primary payor or CoverKids.
 - c. Pharmacy providers that are found as outliers with high percentages of claims paid by CoverKids with OCC codes "0" (member does not have Other Insurance) and "1" (pharmacy cannot determine the valid Other Insurance identity) shall be audited, and corrective action shall be taken if claims could have been paid by the primary payor.
 - d. Contractor shall ensure that pharmacy providers are not denying benefits to CoverKids enrollees in order to avoid using the TPL/COB process.
26. CoverKids TPL Fees. The State shall not pay Contractor any additional TPL Fees or TPL per claim fees for TPL services described in this Section of the Contract. Contractor shall be compensated for all TPL services as part of their monthly Administration Fee.
- A. CoverKids Monthly TPL Reports. The Contractor shall provide the State with the following TPL reports for the preceding month by the fifteenth (15th) day of each month:
 - a. CoverKids Monthly TPL Claims Detail- The Contractor shall provide a Monthly TPL Claims Detail report that identifies:
 - i. each instance in which a claim has been denied because TPL was identified by the POS system but the prescription was not filled using the TPL information,
 - ii. all claims that were paid using TPL information provided to a pharmacy by the POS system,

- B. The State will work with the Contractor and third party TPL audit vendor on a claims file layout and on a method to transfer this file and confirm receipt.

A.72.e. CoverKids Prospective Drug Utilization Review (Pro-DUR)

1. The Contractor shall duplicate the TennCare Prospective Drug Utilization Review (Pro-DUR) system for use with the CoverKids Program. The Pro-DUR function shall meet minimum TennCare Drug Utilization Review (DUR) requirement, as well as the additional specifications in this section, and be flexible enough to accommodate any future edit changes required by TennCare. The Contractor's system shall provide Pro-DUR services that apply TennCare-approved edits to all claims. The edits shall determine problems with a prescription and shall validate medical appropriateness of the prescribed drug by comparing the circumstances surrounding the request with established pharmacy-related therapeutic criteria.
2. The Contractor's system shall provide Pro-DUR services that apply TennCare-approved edits to all claims. The edits shall determine problems with a prescription and shall validate medical appropriateness of the prescribed drug by comparing the circumstances surrounding the request with established pharmacy-related therapeutic criteria.
3. The Contractor's POS system shall be capable of applying results of Pro-DUR processing in the claim adjudication process. Claims that reject as a result of Pro-DUR processing shall include situation specific messaging and error codes that enable the pharmacy provider to take appropriate actions. The Contractor may use an existing Pro-DUR package but shall make any modifications required by TennCare. The Contractor shall work with TennCare in setting the disposition of Pro-DUR edits that may vary by type of submission (e.g., POS versus batch).
4. The Contractor's system shall include the following minimum prospective drug utilization review (Pro-DUR) features at installation:
 - (a) CoverKids Potential Drug Problems Identification - The Contractor's system shall accept and use only TennCare-approved criteria and shall perform automated Pro-DUR functions that include, but are not limited to:
 - (1) Automatically identify and report problems that involve potential drug over-utilization;
 - (2) Automatically identify and report problems that involve therapeutic duplication of drugs when the submitted claim is associated with other drugs or historical claims identified for a given enrollee;
 - (3) Automatically identify and report problems that involve drug use contraindicated by age, gender and presumed diagnosis codes on historical claims for a given enrollee, or if requested by TennCare, based on actual diagnosis information provided by TennCare in a format mutually agreed upon by Contractor and TennCare;
 - (4) Automatically identify and report problems that involve drug use contraindicated by other drugs on current or historical claims for a given enrollee (drug-to-drug interactions);
 - (5) Automatically indicate and report the level of severity of drug/drug interactions;

- (6) Automatically identify and report potentially incorrect drug dosages or limit the quantity per prescription to ensure the most cost-effective strength is dispensed.
 - (7) Automatically identify and report potentially incorrect drug treatments;
 - (8) Automatically indicate and report potential drug abuse and/or misuse based on a given members prior use of the same or related drugs; and
 - (9) Automatically identify early refill conditions and provide, at the drug code level, the ability to deny these claims;
- (b) CoverKids POS Provider Cancel or Override Response to Pro-DUR Messages – Prior to the final submission of POS pharmacy claims, the Contractor's system shall automatically generate Pro-DUR messages in a manner that shall enable a pharmacy provider to cancel submission of the claim or to submit it if it is a message that can be overridden.
- (c) CoverKids POS Provider Comment on Pro-DUR Messages - The Contractor's system shall allow providers to enter responses utilizing NCPDP Professional Pharmacy Services (PPS) intervention codes in response to Pro-DUR messages. The system shall capture and store all NCPDP standard DUR conflict, intervention, and outcome messages for reporting to TennCare. The Contractor shall make changes to the PPS intervention configuration as directed by TennCare at no cost to the State.
- (d) CoverKids Flexible Parameters for Generation of Pro-DUR Messages - The Contractor's system shall have the ability to transmit new or revised Pro-DUR messages and to define the Pro-DUR criteria that activate these messages. The system shall maintain a TennCare-controlled set of parameters to the situations involving generation of online Pro-DUR messages. The system shall provide and permit the use of all general system parameters regarding data access, support, and maintenance. Variables subject to TennCare definition and control include, but are not limited to: NDC code (including multiple NDC codes subject to potential drug/drug interaction); date of service; drug strength; drug quantity; daily supply; and Generic Product ID (GPI), Generic Drug Code (GCN) or Generic Sequence Number (GSN).
- (e) CoverKids Pro-DUR Enrollee Profile Records - The Contractor's system shall provide and maintain enrollee profiles for Pro-DUR processing of submitted claims. Recipient profiles shall be based on inferred and actual diagnoses from pharmacy claims, actual diagnoses from medical claims provided by TennCare to Contractor, and other available data.
- (f) CoverKids Disease/Drug Therapy Issues Screening - The Pro-DUR system shall have the capability to screen for drug therapy concerns by specific drugs relative to high-risk disease, to include but not limited to: cardiovascular disease; cerebrovascular disease; central nervous system disease; renal disease; endocrine disease; gastrointestinal disease; psychiatric disease; and respiratory disease.
- (g) CoverKids Patient Counseling Support - The Contractor's system shall present Pro-DUR results to pharmacy providers in a format that supports their ability to advise and counsel members appropriately. The system shall be able to print out these instructions for the member.

- (h) CoverKids Emergency Supply Copays – The enrollee shall not be charged a copay for the emergency supply. The emergency supply shall count against the monthly prescription limit. However, if later in the same month the provider obtains a Prior Authorization (PA) or changes to a drug not requiring a PA, the remainder of the prescription and /or the substitute prescription shall not count against the monthly prescription limit.
- (i) Number of Emergency Supplies per CoverKids Enrollee - Only one (1) seventy-two (72) hour supply shall be provided per patient, per prescription. Prescription refers to the entire course of therapy ordered by single prescription (i.e., first fill and subsequent refills included with the order for the first fill).

A.72.f. CoverKids Pharmacy Claim Processing and Payments. The system shall process claims in accordance with existing CoverKids policy and rules and Tennessee regulations for dispensing fees.

1. All payments for pharmacy claims shall be made through the Contractor's system and electronically invoiced to TennCare weekly.
2. Claims pricing is driven by the pricing methodologies set by CoverKids rules and policies. Contractor's system shall have the ability to support any pricing methodology that TennCare adopts. The contractor shall pass one hundred percent (100%) of reimbursement rates in all cases at the exact amounts being charged to the state. Contractor's system shall have the ability to support separate pricing methodologies for various pharmaceutical distribution and provider types if requested by TennCare. The system shall compare the calculated allowed price (i.e., quantity multiplied by price plus the dispensing fee) to the pharmacy's submitted Usual and Customary retail price and authorize payment based on the lower of the two. The Contractor's system shall allow for such any price adjustments submitted by the TennCare Pharmacy Director or his/her appropriate staff to be effective within two (2) business days. The Contractor's system shall allow the use of NCPDP standard Dispense as Written (DAW) codes, which shall be defined by TennCare.
3. The Contractor's system shall have the capability to adjudicate different copays for groups of enrollees based on the enrollee's copay code. The system shall recognize all applicable copays or coinsurance and deduct that amount from the payment made to the pharmacy provider. The Contractor shall be required to report copay information to TennCare as required by TennCare and the TennCare manager of the MMIS.
4. For the purposes of this Contract, an adjudicated claim shall not include a point-of-sale transaction that was canceled by the sender or a claim that was rejected before it could be fully adjudicated.
5. The Contractor shall be responsible for the preparation of any applicable tax information for service provider payments and the federal government (i.e., Form 1099).
6. The Contractor shall be able to support any/all changes to discount rates and standard pharmaceutical pricing methodologies and incorporate them into pharmacy claim pricing policies at the sole discretion of TennCare with no additional cost.

A.72.g. CoverKids Reversals and Adjustments

The system shall provide an efficient means of reversing or adjusting claims before and after the claim has been transmitted to the MMIS. If reversed or adjusted, this additional claim information shall be transferred to MMIS for further processing. TennCare shall not pay the Contractor for reversed, voided or adjusted claims. The Contractor shall process all reversals

requested by TennCare's fiscal unit within thirty (30) days and provide confirmation to TennCare's fiscal unit upon occurrence.

A.72.h. CoverKids Manual Claims

1. TennCare's appeals unit may submit to the Contractor's manual claims unit, paper claims for those members who were eligible to receive pharmacy services at the time services were rendered. Manual claims may contain multiple products and/or services.
2. Each manual claim shall include sufficient information to allow the Contractor to identify the member and the covered product and/or service, which information shall include, but not be limited:
 - (a) the complete member name, including middle initial (if applicable);
 - (b) the amount paid;
 - (c) the name of the pharmacy that dispensed the prescription;
 - (d) prescription fill date;
 - (e) name of product;
 - (f) amount of prescription dispensed; and
 - (g) the number of days prescription was written for.
3. In the event that the claim information does not include the data elements necessary for the Contractor to adjudicate a transaction using the CoverKids POS system, the Contractor shall directly contact the applicable pharmacy, member and/or doctor in order to obtain sufficient documentation containing the missing information. Once the Contractor has received the necessary data elements, the Contractor shall enter the applicable data elements for each transaction into the CoverKids POS system for adjudication. If the contractor does not receive the necessary data elements then they shall notify TennCare appeals unit within ten (10) calendar days from original receipt from TennCare appeals unit.
4. If the transaction is adjudicated by the CoverKids POS system and such adjudication results in a "paid" status, the Contractor shall submit payment directly to the applicable member for the applicable Transaction using the address information contained in the CoverKids POS system.
5. If the transaction is adjudicated by the CoverKids POS system and such adjudication results in a "rejected" status, the Contractor shall inform the TennCare appeals unit.
6. The Contractor shall mail notice to member for all manual claims that could not be reimbursed.
7. The Contractor shall complete the process set forth in Contract Sections A.72.h.1 through 6 above within twenty one (21) calendar days.

A.73. CoverKids Formulary

- A.73.a. At TennCare's option, the Contractor shall manage the CoverKids formulary program in an ongoing manner consistent with its national preferred formulary, which assures that new drugs and clinical information are addressed appropriately. Formulary changes will be reviewed by the Contractors pharmacy and therapeutics committee and coordinated with the Contractor's rebate offers, and financial modeling support.
- A.73.b. The Contractor shall assure that the formulary decision-making process is evidence-based, assures enrollee access to clinically superior drugs, and takes into account the relative cost of therapeutically equivalent drugs. The Contractor shall identify for CoverKids therapeutic alternatives and opportunities for savings, including opportunities to promote competition to drive rebate bidding. The Contractor shall also make recommendations concerning

therapeutic categories that should be avoided with regard to inclusion on the Contractor's national preferred formulary.

- A.73.c. In addition to the requirements set forth in this section, the formulary shall be developed pursuant to the requirements set forth in Section A.8.
- A.73.d. The Contractor shall assume responsibility for administering and maintaining the existing CoverKids formulary, including the existing prior authorization criteria. As the formulary is re-evaluated and/or expanded, the Contractor shall modify the formulary in accordance with its standard national preferred formulary as a result of factors, including, but not limited to, medical appropriateness, manufacturer rebate arrangements, and patent expirations. The Contractor shall prepare and maintain a document suitable for printing or posting to the CoverKids website providing the formulary listing and all applicable drug prior authorization (PA) criteria including step-therapy algorithms. Prior authorization criteria and procedures shall be fully disclosed to TennCare.
- A.73.e. A listing of quantity limits consistent with the national formulary, with approval from TennCare, shall be included in the formulary documents and coded into the CoverKids POS system.
- A.73.f. The CoverKids formulary shall be designed to maximize the prescribing and dispensing of safe and clinically effective drugs within each therapeutic class that are the most cost-effective.
- A.73.g. The Contractor's formulary design shall include a stringent clinical review of clinical guidelines and medical literature to identify which agents and classes of drugs shall be subject to the formulary program. Within the classes of drugs determined to be subject to the formulary, the Contractor shall determine which drugs within each class are safe, clinically effective, and provide equivalent clinical outcomes.
- A.73.h. The Contractor shall design, develop, test and implement an electronic interface with the Contractor's POS pharmacy claims processing system and mail order program to assure timely transmission and uploading (posting) of prior authorization data from the Prior Authorization Call Center to the CoverKids POS pharmacy system.
- A.73.i. The Contractor shall monitor its formulary management programs, including but not limited to therapeutic interchange, communications with Members, participating pharmacies, and/or physicians.
- A.73.j. CoverKids Formulary Design, Development, and Implementation
 - 1. The Contractor shall use pharmacoeconomic modeling and evidence-based data in the maintenance of the national formulary that ensures clinically safe and effective pharmaceutical care and yields the highest overall level of cost effectiveness.
 - 2. The Contractor's formulary development and criteria shall be coordinated with the Contractor's Prior Authorization Unit to ensure scalable processes and minimize enrollee or prescriber impact.
 - 3. The Contractor shall design, develop and implement an ongoing, broad-based educational effort to ensure that prescribers and pharmacists are fully aware of the CoverKids formulary and prior authorization requirements. Prior to the program implementation, the Contractor shall submit educational plans to TennCare for review and approval.
 - 4. The Contractor shall ensure that the CoverKids-POS pharmacy claims processing system and mail order program fully integrates the CoverKids formulary and prior authorization programs.

5. For the term of this Contract, the Contractor shall comply with all applicable federal and state statutes, regulations, rules and policy requirements and all applicable administrative rules, statutes, policies, guidelines and Section A.8.
6. The Contractor shall ensure that the CoverKids formulary program and CoverKids-POS system and mail order program include provisions for:
 - (a) Prior authorization decisions to be made within twenty-four (24) hours of receipt of all necessary information, and timely notification of the prescribing physician;
 - (b) Prescriber and pharmacy provider education, training and information regarding the CoverKids formulary prior to implementation of any changes, and ongoing communications to include computer and website access to information; and
 - (c) The Contractor shall ensure that all prescribers and pharmacy providers have timely and complete information about all drugs on the CoverKids formulary. The Contractor shall make such information available through written materials and via the Internet.
7. The Contractor shall support the management and coordination of all activities related to the maintenance of the CoverKids formulary. Activities shall include but not be limited to the following:
 - (a) The Contractor shall present to the CoverKids clinical reviews of new brand-name drugs and new generic drugs for clinical safety and efficacy, and make recommendations regarding possible inclusion in the CoverKids formulary.
 - (b) The Contractor shall annually review drugs within chosen therapeutic classes in order to affirm or change the recommendations to TennCare regarding rebate strategies.
 - (c) The Contractor shall review drug criteria and recommend proposed changes for the Contractor's National formulary based on new clinical and pharmacoeconomic information, if requested by TennCare. The Contractor shall conduct class reviews of all existing therapeutic categories over a time-frame to be co-developed with TennCare.
 - (d) The Contractor shall continually and proactively review all products for changes in cost information, including increases and decreases in rebates as they affect the Contractor's National formulary.

A.73.k. CoverKids Rebate Administration

1. The Contractor shall process, invoice and collect rebates through the Contractor's rebate administration systems, and shall assume all responsibility for uncollected receivables at the time of the contract date. The Contractor's system shall be capable of payment tracking and reconciliation and dispute resolution for disputes related to rebate unit issues and utilization. The Contractor shall import historical quarterly rebate data into their rebate management system, provided by TennCare's current CoverKids rebate vendor. The Contractor shall assume all administrative and management tasks associated with rebates for historical quarters as well as future quarters occurring during the contract period. The Contractor shall generate and issue quarterly invoices for rebates. The Contractor shall provide the designated TennCare staff data files that contain the specific information and in the specified format as required by TennCare. The quarterly rebate invoices shall be generated for all pharmaceutical manufactures and TennCare approval.

2. The Contractor shall ensure that written notifications are sent to pharmaceutical manufacturers concerning past-due rebate payments for undisputed account balances. Past-due balances shall be identified when they are at forty-five (45), seventy-five (75) and ninety (90) days of delinquency. The Contractor shall provide TennCare with monthly reports, due ten (10) business days after the end of the month for the reporting period, detailing past-due notifications sent to drug manufacturers.
3. Dispute resolution pertaining to units billed for rebates shall be done by the Contractor based on unit resolution performed on Rebates. The Contractor shall perform all dispute resolution activities with pharmaceutical manufacturers pertaining to rebate calculations and collections. The Contractor shall present for TennCare approval remedies for all disputes within ninety (90) days of dispute. TennCare shall have final approval of all settlements negotiated.
4. One hundred percent (100%) of all monies collected on behalf of the State shall be remitted to the State. The Contractor agrees that all rebates collected on behalf of the State shall be collected for the sole benefit of the State's share of costs, and that no other monies other than rebates shall be collected based on the State's program.
5. The Contractor shall provide to the agency or business of the State's choosing, any and all appropriate, accurate, and balanced pharmacy level claims data needed to resolve or avoid any drug rebate disputes. This pharmacy level claims data shall be provided within fifteen (15) business days of the request by TennCare.

A.74. CoverKids Technical Requirements

A.74.a. CoverKids Grievance and Appeal Records. Contractor, and as applicable its subcontractors, shall retain enrollee grievance and appeal records in 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

A.74.b. CoverKids MMIS Interface. Operation of the CoverKids-POS requires ongoing interfaces with MMIS. The Contractor shall coordinate with TennCare to design and maintain an effective interface between MMIS and the Contractor's system for pharmacy claims processing, Pro-DUR and financial systems.

1. In order to ensure the security and confidentiality of all transmitted files, the Contractor shall have a system that establishes a dedicated communication line connecting MMIS to the Contractor's processing site. The cost of this communication line is to be borne solely by the Contractor. This dedicated communication line shall meet specifications of TennCare, STS and the State of Tennessee.
 - (a) All circuits, circuit terminations and supported network options are to be coordinated through the Director of Information Services, TennCare, 310 Great Circle Road, Nashville, Tennessee 37243.
 - (b) Contractor shall contact the State before placing all line orders.
 - (c) Contractor shall provide compatible mode table definitions and NCP configurations for all non-standard system generations.
 - (d) Contractor shall supply both host and remote modems for all non-State initiated circuits.
 - (e) Dial-up access into production regions shall be prohibited.

2. After the pre-implementation conversion process, transaction data that changes baseline MMIS files shall be transferred to the Contractor's system on a daily basis unless TennCare approves a less frequent schedule. The system design shall be finalized during the (DDI) phase and shall result in the daily update of the CoverKids-POS system with the most current information from MMIS. This may include, but not be limited to: recipient eligibility, prior authorization information, provider, and reference information.
3. The format of the data exchange shall be determined during DDI and shall resolve any incompatible data format issues that may exist between the Contractor's system and MMIS. MMIS may be modified to expand certain fields. Although no significant changes to MMIS file structures are anticipated, the MMIS may be enhanced to improve data compatibility between the POS environment and MMIS. The Contractor shall make changes as needed, at no cost to TennCare.
4. Daily batch files shall be transmitted from MMIS to the Contractor and from the Contractor to MMIS. The transmission from MMIS may contain, but not be limited to: recipient and provider eligibility records, claim history, prior authorization information and drug formulary information (Procedure Formulary File or PFF). The recipient identification number is currently a nine (9) byte record and is the key indicator for the eligibility record, but this is subject to change at CMS' direction. This number is constant for a given recipient. The transmission of data from the Contractor to the MMIS shall contain records of processed, adjudicated and paid claims.
5. The Contractor shall be required to notify TennCare, in a manner agreed to by TennCare each time a file is received from TennCare in order to verify transmission and receipt of the files.

A.74.c. CoverKids POS Network (CoverKids POS) Interfaces.

1. At initial system implementation, data transmissions between the CoverKids-POS and the pharmacy providers shall be in National Council on Prescription Drug Programs' (NCPDP) most current version. As updates to the NCPDP format become available, the CoverKids-POS Contractor shall maintain compatibility both with Providers using the updated version and those using the superseded versions. Compatibility maintenance for each superseded version shall continue until the updated version becomes generally available and TennCare has approved discontinuation of such maintenance.
2. The Contractor shall support pharmacy providers in their interaction with the CoverKids-POS and coordinate with Network vendors to ensure smooth operation of the CoverKids-POS with the commercial pharmacy POS environment. The Contractor shall establish testing procedures and certify provider practice management systems (i.e., "switches") as compatible and ready to interface with the CoverKids-POS. The Contractor shall not be required to supply hardware or software to pharmacy providers.
3. The Contractor shall develop, maintain and distribute to pharmacy providers a pharmacy procedure and billing manual. Manuals shall be posted on the Contractor's dedicated CoverKids website and distributed to pharmacies with acknowledgement of Network participation. The manuals shall provide instructions to providers regarding the process by which the provider receives payment, in order to diminish the potential for incorrect billing and the need for adjustments or recoupments. The content of the manuals shall be approved by TennCare before distribution.
4. The Contractor may not use its position as the CoverKids pharmacy claims processing agent to create barriers to providers, or pharmacy practice management

vendors who wish to participate in the CoverKids-POS. The Contractor shall not charge connection or access fee to pharmacies or switching companies.

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

A.74.d. CoverKids POS Interface Software. The Contractor shall provide software to allow TennCare to test the Contractor's system through the Contractor's National Pharmacy Network. During the DDI Phase, TennCare shall test submission and receipt of NCPDP point-of-sale transactions. After implementation, and during the term of this Contract, TennCare shall test and audit performance of the system. An ongoing project plan shall be required to coordinate a software release schedule and detail how TennCare and/or MMIS efforts are to be coordinated.

A.74.e. CoverKids POS System Availability Requirements.

1. The Contractor shall ensure that the cumulative system downtime shall not exceed two (2) hours during any continuous five (5) day period.
2. The CoverKids-POS system shall be available twenty-four (24) hours per day, seven (7) days per week, for provider inquiry or billing purposes. Such availability shall include all normal forms of entry. The Contractor may have scheduled maintenance downtime that is pre-approved by the State.

A.74.f. CoverKids System Maintenance and Modification Deadlines and Damages. System maintenance problems shall be corrected within five (5) business days or by a State-approved correction date.

A.74.g. CoverKids System Security. The Contractor shall apply recognized industry standards governing security of State and Federal Automated Data Processing systems and information processing. At a minimum, the State requires the Contractor to conduct a security risk analysis and the results shall be included in the Information Security Plan provided during the DDI phase. The risk analysis shall also be made available to appropriate Federal agencies. As determined by the State to be appropriate, the following specific security measures may be included in the system design documentation, operating procedures and State agency security program:

1. Computer hardware controls that ensure acceptance of data from authorized networks only;
2. Placement of software controls, at the Contractor's central facility, that establish separate files for lists of authorized user access and identification codes;
3. Manual procedures that provide secure access to the system with minimal risk;
4. Multilevel passwords, identification codes or other security procedures that shall be used by State or Contractor personnel;
5. All CoverKids-POS software changes subject to TennCare approval prior to implementation; and
6. System operation functions segregated from systems development duties.
7. Contractor shall complete a third-party penetration test every three hundred sixty-five (365) days or in the event of a major change in the system. All medium, or higher,

risk findings shall be communicated to TennCare Security within one (1) week of the finding. The testing shall, at minimum, include the SANS top ten (10) for the application and database servers with both automated and manual evaluation methods. A penetration testing report must be sent to TennCare Security prior to "go-live".

A.74.h. CoverKids Third Party Administrator Requirement.

1. The Contractor shall qualify as an Administrator (also described as "Third Party Administrator") in compliance with TCA § 56-6-401, *et seq.* and shall be licensed to operate as an adjuster or settler of claims in connection with pharmacy benefits coverage in the State of Tennessee and shall be capable of providing or arranging for health care services provided to covered persons for whom it received payment and is engaged in said business and is shall do so upon and subject to the terms and conditions hereof.
2. If during the term of this Contract, TennCare directs the Contractor, through a contract amendment, to operate as a risk-bearing entity for pharmacy services, the Contractor shall establish and maintain all financial reserves required by the Tennessee Department of Commerce and Insurance of HMOs, Third Party Administrator, or Prepaid Limited Health Services Organization licensed by the State of Tennessee, including, but not limited to, the reserves required by TCA § 56-32-112 as amended or Tennessee Code Annotated § 56-51-136 as amended. The Contractor shall demonstrate evidence of its compliance (or process of compliance) with this provision to the Tennessee Department of Commerce and Insurance, TennCare Division, in the financial reports filed with that Department by the Contractor.

A.74.i. CoverKids Member Identification Cards.

1. The Contractor shall provide each CoverKids member with permanent pharmacy benefit identification (ID) card and prescription drug booklet including mail order information. This shall occur at least three (3) weeks prior to the commencement of the Contractor processing claims. The card shall comply with all state laws and NCPDP guidelines, as amended, regarding the information required on the card, as well as any other information required by TennCare, and must be approved by TennCare. In no event shall the Contractor print or otherwise include the individual CoverKids enrollee's Social Security Number on any identification card required for the individual to access products or services provided under this Agreement. The Contractor shall provide pharmacy benefit identification cards for new CoverKids members added to the CoverKids eligibility file on an ongoing basis. The Contractor shall establish a process that allows enrollees to request replacement cards. Replacement and new cards shall be produced and mailed by the Contractor on the 15th day of each month.
2. The Contractor shall establish and maintain a process to produce ID cards for new enrollees and issue replacement ID cards upon request from a CoverKids member. The Contractor shall be reimbursed for actual postage costs. Such costs shall be billed on a monthly basis to TennCare in addition to regular invoices and shall include substantiating documentation. The cost related to the production of the identification cards shall be included in the Contractor's base rate in this Contract.
3. Other mailings pursuant to this Contract shall be mailed first class unless otherwise directed by the State. The actual postage cost shall be a pass-through item and shall be billed on a monthly basis to TennCare in addition to regular invoices and shall include substantiating documentation. Printing and supply costs are to be included in the base rate of this Contract. The Contractor shall not invoice CoverKids for Contractor business' operations.

4. The Contractor shall provide to members a mail-order pharmacy option capable of processing member prescription volume. Contractor shall provide a toll-free telephone number to the pharmacy mail-order program and include information about accessing the mail-order program in the member welcome letter. All completed, fillable, mail-order pharmacy prescriptions must be dispensed with a maximum turnaround time of forty-eight (48) hours.

A.74.j. CoverKids Returned Mail.

The Contractor shall track returned mail and shall report monthly to CoverKids the number of pieces of returned mail, the reason the mail was returned and action taken by the Contractor. Included in this report shall be a list of all enrollees whose mail was undeliverable due to an incorrect address provided by TennCare. This monthly report is due ten (10) business days after end of month of reporting period, beginning the first full month after the report format has been agreed to by all parties. Nothing in this section shall prevent the Contractor from sub-contracting responsibilities returned mail to a vendor approved by TennCare.

A.74.k. CoverKids Shared Website.

1. The Contractor shall develop and maintain a State approved up-to-date web-site dedicated to CoverKids that shall aid providers and enrollees in all aspects of the pharmacy program.
2. The web-site shall be available for TennCare approval at least three (3) months prior to the commencement of claims processing and be available on the internet two (2) weeks prior to the commencement of claims processing.
3. The web-site shall contain a home page with general pharmacy information with links to dedicated areas for prescribers, pharmacists and enrollees. Each of these sections shall contain information that shall answer, in an interactive format, the majority of questions that each group would ask. This shall include, but it not limited to:
 - (a) Home Page, which includes:
 - (1) General information related to pharmacy benefits, and recent changes occurring within the CoverKids Pharmacy Program, including pertinent fact sheets;
 - (2) Access to an interactive CoverKids Formulary with links to Clinical Criteria, Step Therapy criteria, and Quantity Limits, Auto-exemption and Provider Attestation lists, and Prior Authorization Forms;
 - (3) Civil rights language and links; and
 - (4) Provider Log-in/Register access and features to access Web PA (prescribers)
 - (b) Prescriber Page, which includes:
 - (1) An interactive CoverKids Formulary of the pharmacy program, complete with hot links from drugs to the prior authorization (PA) criteria established for those drugs and also linked to drug specific PA facsimile forms and drug specific web-based PA application;
 - (2) A search function which allows providers to enter a drug name and be routed to the drug in the interactive formulary;
 - (3) Procedures for obtaining Prior Authorizations (PA's)
 - (4) Call Center hours of operation and contact numbers;
 - (5) Printable education material specific to prescribers; and
 - (6) Access to Web PA.

- (c) Pharmacist Page, which includes:
 - (1) A link to the Contractor's National formulary;
 - (2) Printable on-line pharmacy handbook and Provider Education Material specific to Pharmacist;
 - (3) Patient forms:
 - i. Prior Authorization Required Form (PARF) (English and Spanish), and
 - ii. Tamper Resistant Denial Notice (English and Spanish).

- (d) Enrollee Page, which includes:
 - (1) A description of services provided including limitations, exclusions and out-of-Network use;
 - (2) Frequently Asked Questions that answer questions regarding what to do if the enrollee is unable to fill a prescription because PA is required, but has not been obtained, including information on the enrollee-initiated PA process;
 - (3) Printable education material specific to enrollees; and
 - (4) On-line search, by address or zip code, to locate the Network pharmacies nearest to the enrollee.

A.74.I. CoverKids Contractor's System – General. The Contractor's system shall be a secure, HIPAA-compliant and data-encrypted electronic system. The system shall have the ability to be easily customized and have interactive communication capabilities to meet the needs of TennCare and its providers. The Contractor shall provide support and maintenance of the website and guarantee any data exchange between the Contractor and TennCare or its providers and enrollees shall be secure and compliant with current HIPAA guidelines concerning data encryption and/or password protection. TennCare shall transmit eligibility/enrollment information to the Contractor by the standard HIPAA 834 Transaction defined by the TennCare Companion Guide. The Contractor shall load and apply this information to daily to identify those enrollees who have no limits, have no pharmacy benefit, or are subject to limits, and make necessary systems changes to process claims accordingly. The NCPDP Post-Adjudication 4.5 format shall be used for encounter reporting sent to TennCare.

A.75. The Contractor shall accept enrollees in the order in which applications are approved and enrollees are assigned to the Contractor (whether by selection or assignment). The Contractor shall accept an enrollee in the health condition the enrollee is in at the time of enrollment and shall not discriminate against individuals on the basis of health status or need for health care services.

A.76. Disenrollment.

A.76.a. A member may be disenrolled from the Contractor's PBM only when authorized by TennCare. The Contractor shall not request disenrollment of an enrollee for any reason.

A.76.b. TennCare shall not disenroll members for any of the following reasons:

- 1. Adverse changes in the enrollee's health;
- 2. Pre-existing medical or behavioral health conditions;
- 3. High cost medical or behavioral health bills;
- 4. Failure or refusal to pay applicable TennCare cost sharing responsibilities, except when this results in loss of eligibility for TennCare;
- 5. Enrollee's utilization of medical or behavioral health services;
- 6. Enrollee's diminished mental capacity; or

7. Enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the PBM seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).

A.77. CoverKids Drug Utilization Review and Provider Education

A.77.a. CoverKids Retrospective Drug Utilization Review (Retro-DUR)

The Contractor shall provide TennCare with a Retrospective Drug Utilization Review (Retro-DUR) program. The Retro-DUR system shall trend providers' prescribing habits and identify those who practice outside of their peers' norm. The Contractor's Retro-DUR system shall also identify patients who may be abusing resources through poly-pharmacy utilization patterns or visiting multiple providers. The Contractor shall produce reports that detail patient and prescriber trends and that identify potential quality of care problems and/or potential fraud and abuse.

A.77.b. Prior Authorization (PA) Process

1. Contractor shall use its national PA Unit to provide CoverKids PA services. Upon receipt of a request by telephone, facsimile, or in writing, the Prior Authorization Unit shall query patient and/or drug information. If the request is consistent with the prior authorization and/or medical necessity criteria consistent with national formulary procedures. The Contractor shall have appropriate clinical personnel review and approve or have pharmacists deny such requests in accordance with criteria established by the Contractor, the request shall be documented in the Contractor pharmacy case management system and entered as an override in CoverKids-POS system for the appropriate period of time.
2. The Contractor shall generate a notice to the requestor for all prior authorization request determinations as specified in this Contract and the notice shall include specific reason for denial, including, but not limited to listing preferred agents within the class that have not been tried by the member. If the request requires further escalation or the prescriber requests reconsideration of a denied PA request, the request shall be forwarded to the Contractor's physician for reconsideration and final review. A physician shall review all reconsideration requests for denials and shall be available by telephone at all times for clinical support.

A.77.c. Prior Authorization Peer-to-Peer Reconsideration. The Contractor shall have a peer-to-peer reconsideration process, administered by a board certified physician, available to providers who wish to challenge adverse prior authorization decisions. This process shall ensure that appropriate decisions are made and communicated to the prescriber within one (1) business day of the initial request by a prescriber. The Contractor shall develop policies and procedures regarding the peer-to-peer reconsideration processes. These shall be reviewed and approved by TennCare prior to implementation. The Contractor shall notify providers of the reconsideration process with respect to re-review of adverse prior authorization decisions.

A.77.d. CoverKids Enrollee Grievance and Appeal System. Contractor shall have an internal, one-level Grievance and Appeal System in place for CoverKids members, as required by 42 CFR 457.1260. The Contractor shall use the same Grievance and Appeal System for CoverKids that it uses for TennCare enrollees set forth in Section A.46.d above, with the exception that CoverKids members do not have a right to receive continuation of benefits, and do not have a right to receive a State fair hearing as a component of the CoverKids appeal process. As permitted under federal and State law, TennCare, at its sole discretion, may delegate back to itself and the State any portion of the appeal process that the Contractor is obligated to perform.

CoverKids members shall have the right to file appeals regarding adverse benefit determinations taken by the Contractor. For purposes of this requirement, appeal shall mean a member's right to contest any denied claim.

1. The Contractor shall have sufficient support staff (clerical and professional) available to process appeals. Staff shall be knowledgeable about applicable state and federal

law, CoverKids rules and regulations, and governing appeal procedures, as they become effective.

2. The Contractor shall educate its staff concerning the importance of the appeals procedure, the rights of the member, and the time frames in which action shall be taken by the Contractor regarding the handling and disposition of an appeal.
3. The Contractor shall ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, CoverKids rules and regulations, and appeal procedures as they become effective. When the Contractor approves or denies an appeal, the Contractor will assure that the enrollee is notified of its decision.
4. The Contractor is responsible for eliciting pertinent medical history information from the treating provider(s), as needed, for purposes of making medical necessity determinations. Outreach shall be in the form of phone call, facsimile, and/or email. The Contractor shall take whatever action necessary to fulfill this responsibility within the required appeal timelines as specified by TennCare and/or applicable CoverKids rules and regulations.
5. Upon receipt of a TennCare generated On Request Report (ORR), the Contractor shall determine if an administrative review by the Contractor has been completed. If the administrative review has been completed by the Contractor, the Contractor shall include in the ORR response all information reviewed by the Contractor in reaching its decision. If the Contractor's administrative review has not been completed, the Contractor will review its previous decision and issue a written decision to the parent or authorized representative within thirty (30) days of receipt of the request for review. If the parent or authorized representative requested an expedited review and the Contractor completed an expedited review, the ORR shall be returned to TennCare within one (1) business day. If the parent or authorized representative requested a standard review and the Contractor completed a standard review, the ORR shall be returned to TennCare within two (2) business days. In ORR responses the Contractor shall provide to the State all information utilized to process the enrollee's review request for State informal review and State committee review.

A.78. Pharmacy Help Desk

- A.78.a. The Contractor shall operate a technical Pharmacy Help Desk with the capability to promptly respond to systems and claims submission inquiries from pharmacies providing services to CoverKids members. Pharmacy inquiries arising from eligibility, benefit and DUR edits shall be resolved by this unit. The Help Desk shall also function as a recipient customer service unit. Technical and recipient customer service unit hours of operation shall be twenty four (24) hours per day and seven (7) days per week. In no event shall the Help Desk be in an off shore location.
- A.78.b. TennCare will provide the Contractor with toll-free number for the CoverKids PBM, but the Contractor shall contract, at no additional cost to the State, with an acceptable telephone service carrier to provide the required telephone and facsimile services during the term of this Contract. The Contractor shall be responsible for payment of all such telephone service charges. The Contractor shall operate the toll-free telephone number with sufficient capacity that daily call blockage rates do not exceed point twenty-five percent (0.25%). These toll-free numbers shall be transferred back to TennCare upon Contract termination. The Contractor shall provide TennCare with the Help Desk's transfer plan for the toll-free numbers from the existing TennCare PBM contractor to the Contractor no less than sixty (60) days prior to the date the Contractor assumes full responsibility for the pharmacy benefits program. All telecommunication transaction costs are included in the Contractor's compensation set forth in Section C of the Contract, and shall be the sole responsibility of the Contractor.
- A.78.c. The Contractor shall install, operate, monitor and support an automated call distribution system that has capability to provide messaging regarding time to live agent pick up, tele-

FAQs and fax-on-demand. The contractor's system shall record all calls in a digital format. The contractor shall allow TennCare staff to monitor calls in real-time and hear specific calls made to the Help Desk if TennCare provides the date, time or callers number.

- A.78.d. The Contractor shall operate, monitor and support a contact management system that has capability to provide the management and on request reporting needs of TennCare.
- A.78.e. The Contractor shall provide sufficient staff, facilities, and technology such that the Technical Help Desk achieves speed to answer calls within thirty (30) seconds on at least twenty-seven (27) days per month and call abandonment rates are less than two percent (2%) on more than three (3) days per month.
- A.78.f. All Help Desk inquiries that require a call back shall be returned within one (1) business day of receipt one hundred percent (100%) of the time.
- A.78.g. The Help Desk shall have efficient escalation process with a pharmacist onsite at all times, in order to be able to respond to escalated inquiries within one (1) hour or emergency inquiries immediately.
- A.78.h. CoverKids Network Access. The Contractor shall maintain under contract a network of pharmacy providers to provide CoverKids covered services such that in
 - i. urban areas, transport access is at least three (3) miles travel distance and at least fifteen (15) minutes travel time as measured by the GeoNetworks® Accessibility Overview Analysis or such other software program as the State may specify;
 - ii. Suburban areas transport access is at least ten (10) miles travel distance and at least twenty (20) minutes travel time as measured by the GeoNetworks® Accessibility Overview Analysis or such other software program as the State may specify; and
 - iii. Rural/Frontier areas transport access is at least twenty-five (25) miles travel distance and at least thirty (30) minutes travel time as measured by the GeoNetworks® Accessibility Overview Analysis or such other software program as the State may specify.
 - iv. Exceptions shall be justified and documented to the State on the basis of community standards. When requested by TennCare, the Contractor shall make arrangements to provide pharmacy services to enrollees residing in locations where a suitable network provider is not available. The Contractor shall make services available twenty four (24) hours a day, seven (7) days a week, when medically necessary.
- A.78.i. CoverKids Monthly Provider Enrollment File. The Contractor shall submit a monthly Provider Enrollment File that includes information on all providers of CoverKids pharmacy services. The Contractor shall submit this report in the format agreed to by TennCare. The Contractor shall submit this report by the 5th day of each month, or as otherwise requested by TennCare. Each monthly Provider Enrollment File shall include information on all providers of CoverKids pharmacy services and shall provide a complete replacement for any previous Provider Enrollment File submission. Any changes in a provider's contract status from the previous submission shall be indicated in the file generated in the month the change became effective and shall be submitted in the next monthly file.
- A.78.j. CoverKids Pharmacy Audit. The Contractor shall establish and maintain a Program Integrity process. The process shall detect and prevent errors, fraud or abusive pharmacy utilization by enrollees, pharmacies or prescribers. The Contractor shall also review children's prescriptions at POS to screen for possible fraudulent attempts by adult recipients to obtain

prescriptions for themselves. Pharmacies with aberrant claims or trends shall be contacted by the Contractor's staff to gain an acceptable explanation for the finding or to submit a corrected claim. The Contractor shall develop a trend or log of aberrations that shall be shared with TennCare. Each quarter the Contractor shall summarize findings from the reports and meet with TennCare to address program revisions. Revisions to the desk audit reports and review process shall be provided at no cost to TennCare. Program Integrity activities shall be summarized and reported to TennCare pursuant to written instructions from the State. This section in no way limits or circumscribes, or supplants the requirements established in Sections A.23, A.24, and A.25 of this Contract.

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

A.79. CoverKids Reporting Requirements

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

A.79.a CoverKids Management Reports. The Contractor shall provide TennCare with State approved electronic utilization and financial management reports including but not limited to the reports identified on Attachment F of this Contract. The Reports shall be provided to the State in a format agreed upon by the parties using templates provided to the Contractor in a Control Memorandum.

A.79.b. Additional CoverKids Capabilities and Custom Reports. In addition to standard management reports, the Contractor shall provide the following additional capabilities and custom reports as indicated below, or as modified by the State in writing, in a format agreed to by TennCare.

1. CoverKids Clinical Initiative Reports. As clinical programs are implemented, the Contractor's staff shall coordinate with TennCare to define additional reports to gauge the effectiveness of various clinical initiatives, including movement of market share within given therapeutic categories of the formulary. The criteria and format for clinical initiative reporting shall be mutually agreed upon by TennCare and the Contractor. The Contractor's utilization management reporting package shall be customizable to meet CoverKids program analysis needs.
2. CoverKids On Request Reports (ORRs) and Ad Hoc Reports. The Contractor shall be able to provide, at no extra cost to the State ORRs and Ad Hoc Reports that shall assist in managing the pharmacy benefit for CoverKids members. ORRs shall be provided in a format agreed to by TennCare and on a reasonable timetable.
3. CoverKids Decision Support Tools. The Contractor shall provide TennCare staff with access to the Contractor's Data Warehouse allowing TennCare to retrieve claims data including raw paid, rejected and reversed claims, provider data (both pharmacies and prescribers), drug data (inactive and active drugs, with historical pricing), enrollee data (all enrollees received on 834 files, including active and

inactive enrollees), and medical data (ICD-10 and procedure codes) along with a user interface that shall allow user defined queries to address managerial concerns that would normally be requested in an ORR. The Data Warehouse that is accessed by the user interface provided by Contractor shall include all fields used in adjudication, and all fields provided to Contractor by TennCare. Contractor shall provide to TennCare a data dictionary which describes each field available in Contractor's Data Warehouse, along with all possible values and a definition of each value in each available field.

The capability shall not diminish the Contractor's responsibility for responding to requests for ORRs. Contractor shall be responsible to offer assistance to TennCare associates using Contractor's Data Warehouse as needed, including both pharmacy staff and other departmental staff's users.

4. **TennCare Staff Online and Remote Access.** The Contractor shall provide the TennCare staff and their designees, including but not limited to TennCare MCOs and other State entities such as Federal and State auditors, the Office of Inspector General, and MFCU/TBI, individual access to the Contractor's CoverKids POS claims system, prior authorization system, decision support system and other information systems as necessary via an online, real time connection at no additional cost.
5. **CoverKids Monthly Batch Claim Operations Reports.** If requested by TennCare, the Contractor shall provide reports of data entry volumes and types of transactions with daily, weekly and monthly summaries.
6. **CoverKids Help Desk and Prior Authorization Call Center Activity Reports.** The Contractor shall produce reports on usage of the Help Desk and Prior Authorization Call Center services, including numbers of inquiries, types of inquiries, and timeliness of responses. Help Desk Activity Reports shall be reported to CoverKids as a split skill daily interval report. Prior Authorization Call Center Activity Reports shall be reviewed by the Contractor daily and report to TennCare immediately when abnormal results occur. If there are no urgent issues from the Prior Authorization Call Center Activity Report, these reports are to be reported to TennCare during quarterly clinical meetings and monthly Call Center conference calls.
7. **Help Desk Reporting.** The Help Desk Call Center reporting shall be reviewed by the Contractor daily and reported to TennCare when there is a deviation of more than ten percent (10%) from the service level requirements set forth herein for a period of three (3) consecutive days. This report shall at a minimum include the following:
 - (a) Total hours of daily call center access provided, and any downtime experienced;
 - (b) Call abandonment rate, and average abandonment time by day;
 - (c) Average answer speed in seconds by day;
 - (d) Average Automatic Call Distribution (ACD) time of calls handled by day;
 - (e) Average wait time per caller;
 - (f) Number of calls answered daily, and
 - (g) Number of calls transferred to CoverKids.
8. **Prior Authorization (PA) Call Center Reporting.** Prior Authorization Call Center reporting shall be reviewed by the Contractor daily and reported to TennCare when PA processing requirements are not met, and at a minimum, shall include the following:
 - (a) Total hours of daily call center access provided, and any downtime experienced;
 - (b) Call abandonment rate, and average abandonment time by day;
 - (c) Average answer speed in seconds by day;

- (d) CoverKids Comprehensive Requests Report. Comprehensive report listing the type and disposition of all requests handled during the month. Report should provide approval rates by drug and therapeutic class;
- (e) CoverKids Request Volume Report. Request volume by prescriber and pharmacy, with indication of the key types of requests being received, including drug names and categories;
- (f) Average ACD time of calls handled by day;
- (g) Total number of intervention requests received by day;
- (h) Total number of PA requests processed by day;
- (i) Total number of PA requests approved by day;
- (j) Total number of PA requests denied by day;
- (k) Total number of intervention requests received by facsimile by day;
- (l) Total number of intervention requests received by U.S. Mail by day, and
- (m) Total number and types of complaints received from CoverKids members regarding any difficulties receiving pharmacy services under the CoverKids Pharmacy Program by day.

A.79.c. CoverKids Member Satisfaction Reports. If requested by TennCare, the Contractor shall conduct random quarterly survey of member satisfaction with its services.

- 1. The surveys shall include content on perceived problems in the quality, availability, and accessibility of care.
- 2. As a result of the surveys, the Contractor shall:
 - (a) Identify and investigate sources of CoverKids member dissatisfaction;
 - (b) Outline action steps to follow up on the findings, and
 - (c) Inform providers of assessment results.
- 3. The Contractor shall evaluate the effects of the above member satisfaction survey and notify CoverKids within (10) business days regarding any ongoing problems determined by the survey.

A.79.d. CoverKids Provider Satisfaction Reports. If requested by TennCare, the Contractor shall conduct periodic surveys of provider satisfaction

A.79.e. CoverKids Formulary Compliance Reports. The Contractor shall monitor compliance by prescribers and pharmacists with the formulary and report that information to TennCare, quarterly. The Contractor shall produce the formulary compliance reports listed below, in a format agreed to by TennCare.

- 1. Cost Savings/Avoidance Report that includes: utilization shifts by drug and drug class; cost savings by pharmacy paid amount and by net cost resulting from changes in prescribing, by drug and drug class; compliance with formulary drug classes by prescribers; expenditure per claim comparison (monthly/quarterly/yearly);
- 2. Quarterly evaluation of the effectiveness of the formulary and Prior Authorization programs;
- 3. Monthly Rebate Negotiations Status Report underway and/or completed, the status of negotiation outcomes and the product-specific financial impact of the rebates on the formulary; and
- 4. Report on Total Estimated and Projected Future Savings from the formulary and Prior Authorization programs when requested by TennCare.

A.79.f. CoverKids Program Integrity Reports. The Contractor shall produce the Program Integrity reports identified below. Monthly reports shall be produced and reviewed monthly by ten (10) business days after end of month by 3:00 pm CT.

1. CoverKids Ingredient Cost/Prescription Report. This monthly report shall identify claims with a total cost that exceeds Two Thousand Dollars (\$2,000.00) at retail. Claims in this report shall be flagged if the product is considered by TennCare to be a specialty drug. The claims must be reviewed by Contractor's clinical pharmacists on a daily basis for reasonableness, and reported to TennCare when/if abnormal results occur, Report to be used to identify incorrect claims submission, for identification medications for steerage to specialty vendors and for identification opportunities to suggest utilization management edits or benefit design changes.
2. CoverKids Override Report. Daily claims paid with unique adjudication rule reporting, as defined and requested by the State.
3. CoverKids Pharmacy Claim Reversals Report. The report shall identify pharmacies for which claim reversals may have manipulated payment by excessive reversals or failure to issue credits. This report identifies pharmacies whose reversals total greater than three (3) percent or less than one percent (1%) of the total submitted prescription claims in a period. The report shall be produced and reviewed monthly by ten (10) business days after end of month.
 - (a) Pharmacy claims denied for Reject Code 70. The report shall identify all claims each week denied for "NDC Not Covered", and the reason for the denial to ensure that drugs that should be paid for are not rejected for this reason.
 - (b) Expense Accumulator Records Requirement. The Contractor shall track annual expenses for each CoverKids member, by individual member and by household, and report such expenses to the State and the applicable CoverKids Managed Care Organization (MCO) to ensure compliance with federal regulations limiting out-of-pocket annual maximum cost-sharing. This information shall be provided to the State and the MCOs in the format designated by the State, via a State-approved transmission method, on the schedule provided to the Contractor in writing by the State.

A.79.g. CoverKids Reports for Other State Agencies. The State, at its discretion, may choose to delegate oversight of portions of this Contract to other agencies. The Contractor shall be required to produce reports for other state agencies in a manner consistent with the terms of this Contract.

A.80. Contractor Communication with CoverKids PBM Program Members. In addition to the communications requirements set forth in Section A.8, the Contractor shall comply with the following provisions:

A.80.a. CoverKids Notices. The Contractor shall be required to send individualized notices to members that comply with the requirements set forth in Section A.8 unless otherwise approved by the State. Template notices shall be approved by the State prior to sending to members. Additionally, the Contractor shall submit timely corrected notices of Adverse Benefit Determination to the State for review and approval prior to issuance to the member.

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

1. Notification that a Prior Authorization request has been denied, which may or may not include a provision for continuation of benefits
 2. Outcomes of a member initiated prior authorization request, which may include:
 - (a) Prescription change;
 - (b) PA granted; or
 - (c) PA denied.
 3. Notification of drug not covered
 4. Notification of blocked prescriber
 5. Notification of pharmacy lock-in and/or notification of escalation or assignment to PA Status
 6. Response to prescriber on outcome of prior authorization request. This may be completed by utilizing facsimile technology
- A.80.b. The Contractor shall clearly document and communicate the reasons for each denial of prior authorization request in a manner sufficient for the provider and member to understand the denial and decide about requesting reconsideration of or appealing the decision.
- A.80.c. The Contractor shall comply with all member notice provisions in CoverKids Rules, and governing the appeal procedures as they become effective.
- A.80.d. Notices shall be mailed daily except Sunday each week. The previous day's claims and/or Prior Authorization requests shall be mailed the following day. Monday mailings shall include letters based on claims denied on Saturday and Sunday. The Contractor shall provide the State with a web-based system to search and view individual notices that have been sent. The Contractor shall have approval to subcontract the notice process as defined herein with the requisite approval from the State, but in no event shall off shore vendors be utilized. The direct postage cost for recipient prescription limit denial letters, prior authorization letters, non-covered drug letters, blocked prescriber letters, and lock in letters shall be a pass through item.
- A.81. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Prospective Payments.
- A.81.a. At the end of thirty (30) days following the end of each calendar quarter during the term of this Contract, the Contractor shall provide a report to the State to assist the State in identifying and confirming claims incurred at an FQHC or RHC and adjudicated within the calendar quarter, for services covered under the CoverKids program for Members covered by CHIPRA. The State shall be responsible for identifying each FQHC and RHC and providing the Contractor with a current and up-to-date list of FQHCs and RHCs for which to pull the report.
- A.81.b. The State shall be responsible for determining the amount of any payment due to each FQHC or RHC pursuant to the prospective payment system ("PPS") as directed by Section 503 of CHIPRA (each, a "Prospective Payment"). The State shall be responsible for any and all remittances of Prospective Payments to a FQHC or RHC. The State and Contractor expressly acknowledge and agree that the State has sole responsibility for determining and issuing the Prospective Payment owed to the FQHC and RHC under the PPS.
- A.81.c. The State shall be responsible for resolving any FQHC or RHC inquiries regarding Prospective Payments, including but not limited to the resolution of any adjustment inquiries and payments or payments returned to the State after remittance to the FQHC or RHC. The State shall have sole responsibility for resolving any overpayment or underpayment of the Prospective Payment to any FQHC or RHC as well as the recovery of any potential third

party liability that may or may not be available to offset against the amount of the Prospective Payment. In addition, the State shall be responsible for providing FQHCs and RHCs any notice, report or other form or filing required by federal or State law for tax, regulatory or other purposes, including without limitation the provision of Form 1099s, related to the Prospective Payment.

- A.81.d. The State may request, and upon request the Contractor shall provide assistance with claims incurred at an FQHC or RHC to resolve any Prospective Payment inquiries at the time the inquiry is presented to the State. The State shall not wait until the end of the quarter to reconcile or the end of the year to resolve FQHC and RHC inquiries.
- A.81.e. For purposes of Contract Section A.81, the Parties expressly acknowledge and agree that the Contractor is acting at the State's direction to provide a quarterly report to the State for the sole purposes of facilitating Prospective Payments to FQHCs and RHCs. The Contractor is not acting as an insurer under the laws of the State of Tennessee. The State is solely responsible for determining the accuracy and appropriateness of any Prospective Payment made to a FQHC or RHC.
- A.81.f. Any obligations imposed on the Contractor for purposes of Contract Section A.81 shall not survive beyond the termination of this Contract and all such obligations hereunder shall be deemed complete and fulfilled upon the termination of this Contract.

A.82 CoverKids Program Pay for Performance.

Pursuant to Contract Section A.38, the Performance Metrics listed below have been selected by the State for the CoverKids PBM Program, to take effect following CoverKids Go Live, pursuant to a Control Directive to be issued by the State. Using these Performance Metrics, the following illustration shows hypothetical results for Contractor's services for one (1) month, including the Performance Metrics Pass/Fail Score, determination of the percentage of the CoverKids Administrative Fee that will not be paid to Contractor for this month and the total amount of CoverKids Administrative Fee that will be paid to Contractor for this month. The Pass/Fail Scores and all figures shown below are for illustration purposes only and shall not be deemed to revise or amend any provisions of this Contract.

Performance Metric	Pass/Fail Criteria	Pass/Fail Score
1. PA Processing	If any of the PA Processing metrics listed below are not met, the Pass/Fail Score shall be a Fail for the month	Pass
1.a. Complete PA requests	Attachment G, Table 3, Item 1	(Pass)
1.b. Pended PAs	Attachment G, Table 3, Item 2	(Pass)
1.c. PA Attestations	Attachment G, Table 3, Item 3	(Pass)
2. Call Center	If either of the Call Center metrics below are not met, the Pass/Fail Score shall be a Fail for the month	Pass
2.a Call Response Time	Attachment G, Table 3, Item 4	(Pass)

2.b Call Abandonment Rate	Attachment G, Table 3, Item 5	(Pass)
3. Reporting	If any of the metrics below are not met, the Pass/Fail Score shall be a Fail for the month	Fail
3.a Required Reports	Attachment G, Table 3, Item 6	(Fail)
3.b Contractor Data Warehouse	Attachment G, Table 3, Item 7	(Pass)
3.c. Ad Hoc Reports and ORR Reports	Attachment G, Table 3, Item 8	(Pass)
4. Adjudication System Performance	If either of the Adjudication System metrics listed below are not met, the Pass/Fail Score shall be a Fail for the month	Fail
4.a System Errors	Attachment G, Table 3, Item 9	(Fail)
4.b Hours of Operation	Attachment G, Table 3, Item 10	(Pass)
5. Pharmacy Network	If any of the Pharmacy Network metrics listed below are not met, the Pass/Fail Score shall be a Fail for the month	Pass
5.a Provider Agreements	Attachment G, Table 3, Item 11	(Pass)
5.b Provider Enrollment	Attachment G, Table 3, Item 12	(Pass)
5.c Pharmacy Panel Assignment	Attachment G, Table 3, Item 13	(Pass)

Performance Guarantee Payment Calculation – Per Contract Section C.3, up to twenty percent (20%) of Contractor’s total monthly CoverKids Administrative Fee shall, as applicable, be reduced by the percentage that reflects Contractor’s Performance Metrics Pass/Fail Score for the month. The total amount of CoverKids Administrative Fee to be paid to Contractor for this month in the above illustration is based on Contractor having passed three (3) of the metrics and failed two (2) metrics and is determined according to the following calculation:

Step 1. Determination of percentage of CoverKids Administrative Fee that will not be paid to Contractor for this month:

Number of Performance Metrics failed	1	2	3	4	5
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Percentage deducted from monthly CoverKids Administrative Fee Payment	5%	10%	15%	20%	20%
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Step 2. Determination of amount of CoverKids Administrative Fee that will be paid to Contractor for this month:

Full amount of monthly CoverKids Administrative Fee – 10% = total amount of monthly CoverKids Administrative Fee to be paid to Contractor.

B. TERM OF CONTRACT:

- B.1. This Contract shall be effective for the period beginning February 22, 2019 (“Effective Date”) and ending on December 31, 2022 (“Term”). The State shall have no obligation for goods delivered or services provided by the Contractor prior to the Effective Date.
- B.2. Renewal Options. This Contract may be renewed upon satisfactory completion of the Term. The State reserves the right to execute up to four (4) renewal options under the same terms and conditions for a period not to exceed twelve (12) months each by the State, at the State's sole option. In no event, however, shall the maximum Term, including all renewals or extensions, exceed a total of ninety-four (94) months.

C. PAYMENT TERMS AND CONDITIONS:

- C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Forty Three Million Five Hundred Thousand Dollars and Zero Cents (\$43,500,000.00) (“Maximum Liability”). This Contract does not grant the Contractor any exclusive rights. The State does not guarantee that it will buy any minimum quantity of goods or services under this Contract. Subject to the terms and conditions of this Contract, the Contractor will only be paid for goods or services provided under this Contract after a purchase order is issued to Contractor by the State or as otherwise specified by this Contract.
- C.2. Compensation Firm. The payment methodology in Section C.3. of this Contract shall constitute the entire compensation due the Contractor for all goods or services provided under this Contract regardless of the difficulty, materials or equipment required. The payment methodology includes all applicable taxes, fees, overhead, and all other direct and indirect costs incurred or to be incurred by the Contractor.
- C.3. Payment Methodology. The Contractor shall be compensated based on the payment methodology for goods or services authorized by the State in a total amount as set forth in Section C.1.
 - 1. The Contractor's compensation shall be contingent upon the satisfactory provision of goods or services as set forth in Section A.
 - 2. The Contractor shall be compensated based upon the following payment methodology:
 - (1) For the transition period of March 1, 2019 – December 31, 2019, there shall be no cost to the State.
 - (2) For TennCare Program services performed from January 1, 2020 through December 31, 2022, the following rates shall apply:

Cost Item Description	Amount (per compensable increment)
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TennCare Administrative Fee (January 1, 2020 – December 31, 2022)	
0-1,200,000 members	\$1,160,315.23 month
1,200,001 – 1,400,000 members	\$1,160,315.23 month
1,400,001 – 1,600,000 members	\$1,160,315.23 month
1,600,001 and up members	\$1,160,315.23 month

(a)
Pursuant to Contract Section A.39, 80% of applicable monthly

administration fee will be paid upon completion of work. However, 20% of TennCare monthly administration fee will be paid according to completion of performance guarantee measures completed accurately and timely as specified in Contract Section A.39 and Attachment G

- (b) Pursuant to Contract Section A.53, the Contractor shall assume risk level of 3 % as submitted by the Contractor in the RFP Cost Proposal response. The percentage Gain/Loss will be calculated as a percentage of the administrative fee amount bid in the RFP Cost Proposal, not the actual administration fee paid after the performance payments are calculated.
- (3) For CoverRx Program services performed from January 1, 2020 through December 31, 2022, the following rates shall apply:

Cost Item Description	Amount (per compensable increment)
CoverRx Administrative Fee (January 1, 2020 – December 31, 2022)	\$16,765.45 / month

*** Pursuant to Contract Section A.62, 80% of applicable CoverRx monthly administration fee will be paid upon completion of work. However, 20% of administration fee above will be paid according to completion of performance guarantee measures completed accurately and timely as specified in Contract Section A.62. and Attachment G.

- (4) For CoverKids Program services performed from January 1, 2020 through December 31, 2022, the following rates shall apply:

Cost Item Description	Amount (per compensable increment)
CoverKids Administrative Fee	\$31,252.65 / month

(January 1, 2020 – December 31, 2022) * (CoverKids Implementation Date Subject to Change)	
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*** Pursuant to Contract Section A.82, 80% of applicable CoverKids monthly administration fee will be paid upon completion of work. However, 20% of administration fee above will be paid according to completion of performance guarantee measures completed accurately and timely as specified in Contract Section A.82. and Attachment G.

- (5) Should the contract be amended for extension of services, the following rates shall apply.

Cost Item Description	Amount (per compensable increment)
TennCare Administrative Fee (January 1, 2023 – December 31, 2023)	
0-1,200,000 members	\$1,160,315.23 month
1,200,001 – 1,400,000 members	\$1,160,315.23 month
1,400,001 – 1,600,000 members	\$1,160,315.23 month
1,600,001 and up members	\$1,160,315.23 month

Cost Item Description	Amount (per compensable increment)
TennCare Administrative Fee (January 1, 2024 – December 31, 2024)	
0-1,200,000 members	\$1,160,315.23 month
1,200,001 – 1,400,000 members	\$1,160,315.23 month
1,400,001 – 1,600,000 members	\$1,160,315.23 month

1,600,001 – and up members	\$1,160,315.23	month
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Cost Item Description	Amount (per compensable increment)	
TennCare Administrative Fee (January 1, 2025 – December 31, 2025)		
0-1,200,000 members	\$1,160,315.23	month
1,200,001 – 1,400,000 members	\$1,160,315.23	month
1,400,001 – 1,600,000 members	\$1,160,315.23	month
1,600,001 and up members	\$1,160,315.23	month

Cost Item Description	Amount (per compensable increment)	
TennCare Administrative Fee (January 1, 2026 – December 31, 2026)		
0-1,200,000 members	\$1,160,315.23	month
1,200,001 – 1,400,000 members	\$1,160,315.23	month
1,400,001 – 1,600,000 members	\$1,160,315.23	month
1,600,001 and up members	\$1,160,315.23	month

***** Pursuant to Contract Section A.39., 80% of applicable monthly administration fee above will be paid upon completion of work. However, 20% of TennCare monthly administration fee above will be paid according to completion of performance guarantee measures completed accurately and timely as specified in Contract Section A.39 and Attachment G**

Cost Item Description	Amount (per compensable increment)	
CoverRx Administrative Fee	\$16,765.45	/ month

(January 1, 2023 – December 31, 2023)		
CoverRx Administrative Fee (January 1, 2024 – December 31, 2024)	\$16,765.45	/ month
CoverRx Administrative Fee (January 1, 2025 – December 31, 2025)	\$16,765.45	/ month
CoverRx Administrative Fee (January 1, 2026 – December 31, 2026)	\$16,765.45	/ month

*** Pursuant to Contract Section A.62, 80% of applicable CoverRx monthly administration fee will be paid upon completion of work. However, 20% of administration fee above will be paid according to completion of performance guarantee measures completed accurately and timely as specified in Contract Section A.62, and Attachment G.

Cost Item Description	Amount (per compensable increment)	
CoverKids Administrative Fee (January 1, 2023 – December 31, 2023)	\$31,252.65	/ month
CoverKids Administrative Fee (January 1, 2024 – December 31, 2024)	\$31,252.65	/ month
CoverKids Administrative Fee (January 1, 2025 – December 31, 2025)	\$31,252.65	/ month
CoverKids Administrative Fee (January 1, 2026 – December 31, 2026)	\$31,252.65	/ month

*** Pursuant to Contract Section A.82., 80% of applicable CoverKids monthly administration fee will be paid upon completion of work. However, 20% of administration fee above will be paid according to completion of performance guarantee measures completed accurately and timely as specified in Contract Section A.82 and Attachment G.

- c. Pass-Through Costs of Actual Expenditures for Certain Mailings to TennCare Enrollees. The Contractor shall use first class U.S. Postal Service rate to distribute and mail TennCare outputs (hard copy and electronic) as directed by TennCare, including but not limited to returned claims, enrollee notices, provider bulletins, provider manuals and special mailings, unless otherwise directed by the State. Postage costs incurred by the Contractor for these mailings shall be treated as pass-through costs. Such costs shall be invoiced on a monthly basis to the State in addition to regular invoices and shall include

substantiating documentation. Each batch shall have its own reconciliation and money remits. No overhead, administrative or other fee shall be added to such pass-through costs.

- C.4. Travel Compensation. The Contractor shall not be compensated or reimbursed for travel time, travel expenses, meals, or lodging.
- C.5. Invoice Requirements. The Contractor shall invoice the State only for goods delivered and accepted by the State or services satisfactorily provided at the amounts stipulated in Section C.3., above. Contractor shall submit invoices and necessary supporting documentation, no more frequently than once a month, and no later than thirty (30) days after goods or services have been provided to the following address:

Division of TennCare
310 Great Circle Road
Nashville, TN 37243

- a. Each invoice, on Contractor's letterhead, shall clearly and accurately detail all of the following information (calculations must be extended and totaled correctly):
- (1) Invoice number (assigned by the Contractor);
 - (2) Invoice date;
 - (3) Invoice Period (period to which the invoices charges are applicable
 - (4) Contract number (assigned by the State);
 - (5) Customer account name: Department of Finance and Administration, Division of TennCare
 - (6) Customer account number (assigned by the Contractor to the above-referenced Customer);
 - (7) Contractor name;
 - (8) Contractor Tennessee Edison registration ID number;
 - (9) Contractor contact for invoice questions (name, phone, or email);
 - (10) Contractor remittance address;
 - (11) Description of delivered goods or services provided and invoiced, including identifying information as applicable;
 - (12) Number of delivered or completed units, increments, hours, or days as applicable, of each good or service invoiced;
 - (13) Applicable payment methodology (as stipulated in Section C.3.) of each good or service invoiced;
 - (14) Amount due for each compensable unit of good or service; and
 - (15) Total amount due for the invoice period.
- b. Contractor's invoices shall:
- (1) Only include charges for goods delivered or services provided as described in Section A and in accordance with payment terms and conditions set forth in Section C;
 - (2) Only be submitted for goods delivered or services completed and shall not include any charge for future goods to be delivered or services to be performed;
 - (3) Not include Contractor's taxes, which includes without limitation Contractor's sales and use tax, excise taxes, franchise taxes, real or personal property taxes, or income taxes; and
 - (4) Include shipping or delivery charges only as authorized in this Contract.
- c. The timeframe for payment (or any discounts) begins only when the State is in receipt of an invoice that meets the minimum requirements of this Section C.5.
- C.6. Payment of Invoice. A payment by the State shall not prejudice the State's right to object to or question any payment, invoice, or other matter. A payment by the State shall not be construed as

acceptance of goods delivered, any part of the services provided, or as approval of any amount invoiced.

- C.7. Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment that is determined by the State, on the basis of audits conducted in accordance with the terms of this Contract, to not constitute proper compensation for goods delivered or services provided.
- C.8. Deductions. The State reserves the right to deduct from amounts, which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the State of Tennessee, any amounts that are or shall become due and payable to the State of Tennessee by the Contractor.
- C.9. Prerequisite Documentation. The Contractor shall not invoice the State under this Contract until the State has received the following, properly completed documentation.
- a. The Contractor shall complete, sign, and present to the State the "Authorization Agreement for Automatic Deposit Form" provided by the State. By doing so, the Contractor acknowledges and agrees that, once this form is received by the State, payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee, may be made by ACH; and
 - b. The Contractor shall complete, sign, and return to the State the State-provided W-9 form. The taxpayer identification number on the W-9 form must be the same as the Contractor's Federal Employer Identification Number or Social Security Number referenced in the Contractor's Edison registration information.

D. MANDATORY TERMS AND CONDITIONS:

- D.1. Required Approvals. The State is not bound by this Contract until it is duly approved by the Parties and all appropriate State officials in accordance with applicable Tennessee laws and regulations. Depending upon the specifics of this Contract, this may include approvals by the Commissioner of Finance and Administration, the Commissioner of Human Resources, the Comptroller of the Treasury, and the Chief Procurement Officer. Approvals shall be evidenced by a signature or electronic approval.
- D.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract, other than information or data that is necessary for one or more Contract deliverables, 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. All communications, regardless of method of transmission, shall be addressed to the respective Party at the appropriate mailing address, facsimile number, or email address as stated below or any other address provided in writing by a Party.

The State:

Deputy Commissioner
Department of Finance and Administration
Division of TennCare
310 Great Circle Road
Nashville TN 37243
Telephone # (615) 507-6444
FAX # (615) 253-5607

The

Contractor:

OptumRx, Inc.
1600 McConnor Parkway
Schaumburg, IL 60173-6801
Attn: Vice President, Client Management

Copy to:

OptumRx, Inc.
1600 McConnor Parkway
Schaumburg, IL 60173-6801
Attn: General Counsel
optumrxct@optum.com

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

- D.3. Modification and Amendment. This Contract may be modified only by a written amendment signed by all Parties and approved by all applicable State officials.
- D.4. Subject to Funds Availability. The Contract is subject to the appropriation and availability of State or federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate this Contract upon written notice to the Contractor. The State's exercise of its right to terminate this Contract shall not constitute a breach of Contract by the State. Upon receipt of the written notice, the Contractor shall cease all work associated with the Contract. If the State terminates this Contract due to lack of funds availability, the Contractor shall be entitled to compensation for all conforming goods requested and accepted by the State and for all satisfactory and authorized services completed as of the termination date. Should the State exercise its right to terminate this Contract due to unavailability of funds, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages of any description or amount.
- D.5. Termination for Convenience. The State may terminate this Contract for convenience without cause and for any reason. The State shall give the Contractor at least thirty (30) days written notice before the termination date. The Contractor shall be entitled to compensation for all conforming goods delivered and accepted by the State or for satisfactory, authorized services completed as of the termination date. In no event shall the State be liable to the Contractor for compensation for any goods neither requested nor accepted by the State or for any services neither requested by the State nor satisfactorily performed by the Contractor. In no event shall the State's exercise of its right to terminate this Contract for convenience relieve the Contractor of any liability to the State for any damages or claims arising under this Contract.
- D.6. Termination for Cause. If the Contractor fails to properly perform its obligations under this Contract in a timely or proper manner, or if the Contractor materially violates any terms of this Contract ("Breach Condition"), the State shall have the right to immediately terminate the Contract and withhold payments in excess of compensation for completed services or provided goods. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any Breach Condition and the State may seek other remedies allowed at law or in equity for breach of this Contract.
- D.7. Assignment and Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the goods or services provided under this Contract without the prior written approval of the State. Notwithstanding any use of the approved subcontractors, the Contractor shall be the prime contractor and responsible for compliance with all terms and conditions of this Contract. The State reserves the right to request additional information or impose additional

terms and conditions before approving an assignment of this Contract in whole or in part or the use of subcontractors in fulfilling the Contractor's obligations under this Contract.

- D.8. Conflicts of Interest. The Contractor warrants that no part of the Contractor's compensation 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 under this Contract.

The Contractor acknowledges, understands, and agrees that this Contract shall be null and void if the Contractor is, or within the past six (6) months has been, an employee of the State of Tennessee or if the Contractor is an entity in which a controlling interest is held by an individual who is, or within the past six (6) months has been, an employee of the State of Tennessee.

- D.9. Nondiscrimination. The Contractor hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor on the grounds of handicap or disability, age, race, creed, color, religion, sex, national origin, or any other classification protected by federal or state law. The Contractor shall, upon request, show proof of nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination. In addition, the Contractor shall comply with the provisions of Contract Section A.6. (Nondiscrimination Compliance Requirements) and this Section D.9 shall not be deemed to limit or abridge any requirement set forth in Section A.6.

- D.10. Prohibition of Illegal Immigrants. The requirements of Tenn. Code Ann. § 12-3-309 addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.

- a. The Contractor agrees that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document at Attachment A, semi-annually during the Term. If the Contractor is a party to more than one contract with the State, the Contractor may submit one attestation that applies to all contracts with the State. All Contractor attestations shall be maintained by the Contractor and made available to State officials upon request.
- b. Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the Term, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work under this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work under this Contract. Attestations obtained from subcontractors shall be maintained by the Contractor and made available to State officials upon request.
- c. The Contractor shall maintain records for all personnel used in the performance of this Contract. Contractor's records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.
- d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Tenn. Code Ann. § 12-3-309 for acts or omissions occurring after its effective date.
- e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not: (i) a United States citizen; (ii) a Lawful Permanent Resident; (iii) a person whose physical presence in the United States is authorized; (iv) allowed by the federal Department of Homeland Security and who, under federal immigration laws or

regulations, is authorized to be employed in the U.S.; or (v) is otherwise authorized to provide services under the Contract.

- D.11. Records. The Contractor shall maintain documentation for all charges under this Contract. The books, records, and documents of the Contractor, for work performed or money received under this Contract, shall be maintained for a period of five (5) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.
- D.12. Monitoring. The Contractor's activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.
- D.13. Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.
- D.14. Strict Performance. Failure by any Party to this Contract to require, in any one or more cases, 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 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.
- D.15. Independent Contractor. The Parties shall not act as employees, partners, joint venturers, or associates of one another. The Parties are independent contracting entities. Nothing in this Contract shall be construed to create an employer/employee relationship or to allow either Party 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 are not employees or agents of the other Party.
- D.16. Patient Protection and Affordable Care Act. The Contractor agrees that it will be responsible for compliance with the Patient Protection and Affordable Care Act ("PPACA") with respect to itself and its employees, including any obligation to report health insurance coverage, provide health insurance coverage, or pay any financial assessment, tax, or penalty for not providing health insurance. The Contractor shall indemnify the State and hold it harmless for any costs to the State arising from Contractor's failure to fulfill its PPACA responsibilities for itself or its employees.
- D.17. Limitation of State's Liability. The State shall have no liability except as specifically provided in this Contract. In no event will the State be liable to the Contractor or any other party for any lost revenues, lost profits, loss of business, decrease in the value of any securities or cash position, time, money, goodwill, or any indirect, special, incidental, punitive, exemplary or consequential damages of any nature, whether based on warranty, contract, statute, regulation, tort (including but not limited to negligence), or any other legal theory that may arise under this Contract or otherwise. The State's total liability under this Contract (including any exhibits, schedules, amendments or other attachments to the Contract) or otherwise shall under no circumstances exceed the Maximum Liability. This limitation of liability is cumulative and not per incident.
- D.18. Limitation of Contractor's Liability. In accordance with Tenn. Code Ann. § 12-3-701, the Contractor's liability for all claims arising under this Contract shall be limited to an amount equal to two (2) times the Maximum Liability amount detailed in Section C.1. and as may be amended, PROVIDED THAT in no event shall this Section limit the liability of the Contractor for: (i) intellectual property or any Contractor indemnity obligations for infringement for third-party intellectual property rights; (ii) any claims covered by any specific provision in the Contract providing for liquidated damages; or (iii) any claims for intentional torts, criminal acts, fraudulent conduct, or acts or omissions that result in personal injuries or death.
- D.19. Hold Harmless. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities,

losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Contractor, its employees, or any person acting for or on its or their behalf relating to this Contract. The Contractor further agrees it shall be liable for the reasonable cost of attorneys for the State to enforce the terms of this Contract.

In the event of any suit or claim, the Parties shall give each other immediate notice and provide all necessary assistance to respond. The failure of the State to give notice shall only relieve the Contractor of its obligations under this Section to the extent that the Contractor can demonstrate actual prejudice arising from the failure to give notice. This Section shall not grant the Contractor, through its attorneys, the right to represent the State in any legal matter, as the right to represent the State is governed by Tenn. Code Ann. § 8-6-106.

- D.20. HIPAA Compliance. The State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Health Information Technology for Economic and Clinical Health ("HITECH") Act and any other relevant laws and regulations regarding privacy (collectively the "Privacy Rules"). The obligations set forth in this Section shall survive the termination of this Contract.
- a. Contractor warrants to the State that it is familiar with the requirements of the Privacy Rules, and will comply with all applicable 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 the Privacy Rules, in the course of performance of the Contract so that both parties will be in compliance with the Privacy Rules.
 - c. The State and the Contractor will sign documents, including but not limited to business associate agreements, as required by the Privacy Rules and that are reasonably necessary to keep the State and Contractor in compliance with the Privacy Rules. This provision shall not apply if information received or delivered by the parties under this Contract is NOT "protected health information" as defined by the Privacy Rules, or if the Privacy Rules permit the parties to receive or deliver the information without entering into a business associate agreement or signing another document.
 - d. The Contractor will indemnify the State and hold it harmless for any violation by the Contractor or its subcontractors of the Privacy Rules. This includes the costs of responding to a breach of protected health information, the costs of responding to a government enforcement action related to the breach, and any fines, penalties, or damages paid by the State because of the violation.
- D.21. Tennessee Consolidated Retirement System. Subject to statutory exceptions contained in Tenn. Code Ann. §§ 8-36-801, *et seq.*, the law governing the Tennessee Consolidated Retirement System ("TCRS"), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established under Tenn. Code Ann. §§ 8-35-101, *et seq.*, accepts State employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this Contract is that of "employee/employer" and not that of an independent contractor, the Contractor, if a retired member of TCRS, may be required to repay to TCRS the amount of retirement benefits the Contractor received from TCRS during the Term.
- D.22. Tennessee Department of Revenue Registration. The Contractor shall comply with all applicable registration requirements contained in Tenn. Code Ann. §§ 67-6-601 – 608. Compliance with applicable registration requirements is a material requirement of this Contract.
- D.23. Debarment and Suspension. The Contractor certifies, to the best of its knowledge and belief, that it, its current and future principals, its current and future subcontractors and their principals:

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

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

- D.24. Force Majeure. "Force Majeure Event" means fire, flood, earthquake, elements of nature or acts of God, wars, riots, civil disorders, rebellions or revolutions, acts of terrorism or any other similar cause beyond the reasonable control of the Party except to the extent that the non-performing Party is at fault in failing to prevent or causing the default or delay, and provided that the default or delay cannot reasonably be circumvented by the non-performing Party through the use of alternate sources, workaround plans or other means. A strike, lockout or labor dispute shall not excuse either Party from its obligations under this Contract. Except as set forth in this Section, any failure or delay by a Party in the performance of its obligations under this Contract arising from a Force Majeure Event is not a default under this Contract or grounds for termination. The non-performing Party will be excused from performing those obligations directly affected by the Force Majeure Event, and only for as long as the Force Majeure Event continues, provided that the Party continues to use diligent, good faith efforts to resume performance without delay. The occurrence of a Force Majeure Event affecting Contractor's representatives, suppliers, subcontractors, customers or business apart from this Contract is not a Force Majeure Event under this Contract. Contractor will promptly notify the State of any delay caused by a Force Majeure Event (to be confirmed in a written notice to the State within one (1) day of the inception of the delay) that a Force Majeure Event has occurred, and will describe in reasonable detail the nature of the Force Majeure Event. If any Force Majeure Event results in a delay in Contractor's performance longer than forty-eight (48) hours, the State may, upon notice to Contractor: (a) cease payment of the fees until Contractor resumes performance of the affected obligations; or (b) immediately terminate this Contract or any purchase order, in whole or in part, without further payment except for fees then due and payable. Contractor will not increase its charges under this Contract or charge the State any fees other than those provided for in this Contract as the result of a Force Majeure Event.
- D.25. State and Federal Compliance. The Contractor shall comply with all applicable state and federal laws and regulations in the performance of this Contract. In addition, the Contractor shall comply with the provisions of Contract Section E.16, (Applicable Laws, Rules, Policies and Court Orders), and this Section D.25 shall not be deemed to limit or abridge any requirement set forth in Section E.16, Applicable Laws, Rules, Policies and Court Orders.
- D.26. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Tennessee Claims Commission or the state or federal courts in Tennessee shall be the venue for all claims, disputes, or disagreements arising under this Contract. The Contractor acknowledges and agrees that any rights, claims, or remedies against

the State of Tennessee or its employees arising under this Contract shall be subject to and limited to those rights and remedies available under Tenn. Code Ann. §§ 9-8-101 - 407.

- D.27. Entire Agreement. This Contract is complete and contains the entire understanding between the Parties relating to its subject matter, 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, whether written or oral.
- D.28. 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 of this Contract shall not be affected and shall remain in full force and effect. The terms and conditions of this Contract are severable.
- D.29. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.
- D.30. Incorporation of Additional Documents. Each of the following documents is included as a part of this Contract by reference. In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this Contract, these items shall govern in order of precedence below:
- a. any amendment to this Contract, with the latter in time controlling over any earlier amendments;
 - b. this Contract with any attachments or exhibits (excluding the items listed at subsections c. through f., below), which includes Attachment A, Definitions and Acronyms, Attachment B, Attestation RE: Personnel Used in Contract Performance and Attachment C, Liquidated Damages; Attachment D, TennCare Management Reporting Requirements; Attachment E, CoverRx Management Reporting Requirements; Attachment F, CoverKids Management Reporting Requirements; Attachment G, TennCare PBM program performance metrics for TennCare Program (Table 1), CoverRx Program (Table 2) and CoverKids Program (Table 3); and Attachment H, Program Risk Sharing Module Illustration, and Attachment I, Sample Administrative and Escrow Agreement.
 - c. any clarifications of or addenda to the Contractor's proposal seeking this Contract;
 - d. the State solicitation, as may be amended, requesting responses in competition for this Contract;
 - e. any technical specifications provided to proposers during the procurement process to award this Contract; and
 - f. the Contractor's response seeking this Contract.
- D.31. Iran Divestment Act. The requirements of Tenn. Code Ann. § 12-12-101, *et seq.*, addressing contracting with persons as defined at Tenn. Code Ann. §12-12-103(5) that engage in investment activities in Iran, shall be a material provision of this Contract. The Contractor certifies, under penalty of perjury, that to the best of its knowledge and belief that it is not on the list created pursuant to Tenn. Code Ann. § 12-12-106.
- D.32. Insurance. Contractor shall maintain insurance coverage as specified in this Section. The State reserves the right to amend or require additional insurance coverage, coverage amounts, and endorsements required under this Contract. Contractor's failure to maintain or submit evidence of insurance coverage, as required, is a material breach of this Contract. If Contractor loses insurance coverage, fails to renew coverage, or for any reason becomes uninsured during the Term, Contractor shall immediately notify the State. All insurance companies providing coverage must be: (a) acceptable to the State; (b) authorized by the Tennessee Department of Commerce and Insurance ("TDCI"); and (c) rated A- / VII or better by A.M. Best. All coverage must be on a primary basis and noncontributory with any other insurance or self-insurance carried by the State. Contractor agrees to name the State as an additional insured on any insurance policy with the exception of workers' compensation (employer liability) and professional liability (errors and omissions) insurance. All policies must contain an endorsement for a waiver of subrogation in favor of the State. Any deductible or self insured retention ("SIR") over fifty thousand dollars (\$50,000) must be approved by the State. The deductible or SIR and any premiums are the

Contractor's sole responsibility. The Contractor agrees that the insurance requirements specified in this Section do not reduce any liability the Contractor has assumed under this Contract including any indemnification or hold harmless requirements.

To achieve the required coverage amounts, a combination of an otherwise deficient specific policy and an umbrella policy with an aggregate meeting or exceeding the required coverage amounts is acceptable. For example: If the required policy limit under this Contract is for two million dollars (\$2,000,000) in coverage, acceptable coverage would include a specific policy covering one million dollars (\$1,000,000) combined with an umbrella policy for an additional one million dollars (\$1,000,000). If the deficient underlying policy is for a coverage area without aggregate limits (generally Automobile Liability and Employers' Liability Accident), Contractor shall provide a copy of the umbrella insurance policy documents to ensure that no aggregate limit applies to the umbrella policy for that coverage area. In the event that an umbrella policy is being provided to achieve any required coverage amounts, the umbrella policy shall be accompanied by an endorsement at least as broad as the Insurance Services Office, Inc. (also known as "ISO") "Noncontributory—Other Insurance Condition" endorsement or shall be written on a policy form that addresses both the primary and noncontributory basis of the umbrella policy if the State is otherwise named as an additional insured.

Contractor shall provide the State a certificate of insurance ("COI") evidencing the coverages and amounts specified in this Section. The COI must be on a form approved by the TDCI (standard ACORD form preferred). The COI must list each insurer's National Association of Insurance Commissioners (NAIC) number and be signed by an authorized representative of the insurer. The COI must list the State of Tennessee – CPO Risk Manager, 312 Rosa L. Parks Ave., 3rd floor Central Procurement Office, Nashville, TN 37243 as the certificate holder. Contractor shall provide the COI ten (10) business days prior to the Effective Date and again thirty (30) calendar days before renewal or replacement of coverage. Contractor shall provide the State evidence that all subcontractors maintain the required insurance or that subcontractors are included under the Contractor's policy. At any time, the State may require Contractor to provide a valid COI. The parties agree that failure to provide evidence of insurance coverage as required is a material breach of this Contract. If Contractor self-insures, then a COI will not be required to prove coverage. Instead Contractor shall provide a certificate of self-insurance or a letter, on Contractor's letterhead, detailing its coverage, policy amounts, and proof of funds to reasonably cover such expenses. The State reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

The State agrees that it shall give written notice to the Contractor as soon as practicable after the State becomes aware of any claim asserted or made against the State, but in no event later than thirty (30) calendar days after the State becomes aware of such claim. The failure of the State to give notice shall only relieve the Contractor of its obligations under this Section to the extent that the Contractor can demonstrate actual prejudice arising from the failure to give notice. This Section shall not grant the Contractor or its insurer, through its attorneys, the right to represent the State in any legal matter, as the right to represent the State is governed by Tenn. Code Ann. § 8-6-106.

The insurance obligations under this Contract shall be: (1)—all the insurance coverage and policy limits carried by the Contractor; or (2)—the minimum insurance coverage requirements and policy limits shown in this Contract; whichever is greater. Any insurance proceeds in excess of or broader than the minimum required coverage and minimum required policy limits, which are applicable to a given loss, shall be available to the State. No representation is made that the minimum insurance requirements of the Contract are sufficient to cover the obligations of the Contractor arising under this Contract. The Contractor shall obtain and maintain, at a minimum, the following insurance coverages and policy limits.

a. Commercial General Liability ("CGL") Insurance

- 1) The Contractor shall maintain CGL, which shall be written on an ISO Form CG 00 01 occurrence form (or a substitute form providing equivalent coverage) and

shall cover liability arising from property damage, premises and operations products and completed operations, bodily injury, personal and advertising injury, and liability assumed under an insured contract (including the tort liability of another assumed in a business contract).

The Contractor shall maintain single limits not less than one million dollars (\$1,000,000) per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this policy or location of occurrence or the general aggregate limit shall be twice the required occurrence limit.

b. Workers' Compensation and Employer Liability Insurance

- 1) For Contractors statutorily required to carry workers' compensation and employer liability insurance, the Contractor shall maintain:
 - i. Workers' compensation in an amount not less than one million dollars (\$1,000,000) including employer liability of one million dollars (\$1,000,000) per accident for bodily injury by accident, one million dollars (\$1,000,000) policy limit by disease, and one million dollars (\$1,000,000) per employee for bodily injury by disease.
- 2) If the Contractor certifies that it is exempt from the requirements of Tenn. Code Ann. §§ 50-6-101 – 103, then the Contractor shall furnish written proof of such exemption for one or more of the following reasons:
 - i. The Contractor employs fewer than five (5) employees;
 - ii. The Contractor is a sole proprietor;
 - iii. The Contractor is in the construction business or trades with no employees;
 - iv. The Contractor is in the coal mining industry with no employees;
 - v. The Contractor is a state or local government; or
 - vi. The Contractor self-insures its workers' compensation and is in compliance with the TDCI rules and Tenn. Code Ann. § 50-6-405.

c. Automobile Liability Insurance

- 1) The Contractor shall maintain automobile liability insurance which shall cover liability arising out of any automobile (including owned, leased, hired, and non-owned automobiles).
- 2) The Contractor shall maintain bodily injury/property damage with a limit not less than one million dollars (\$1,000,000) per occurrence or combined single limit.

D.33. Major Procurement Contract Sales and Use Tax. Pursuant to Tenn. Code Ann. § 4-39-102 and to the extent applicable, the Contractor and the Contractor's subcontractors shall remit sales and use taxes on the sales of goods or services that are made by the Contractor or the Contractor's subcontractors and that are subject to tax.

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, the special terms and conditions shall be subordinate to the Contract's other terms and conditions.
- E.2. 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 that is regarded as confidential under state or federal law shall be regarded as "Confidential Information." Nothing in this Section shall permit Contractor to disclose any Confidential Information, 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. Confidential Information shall not be disclosed except as required or permitted under state or federal law. The Contractor shall only use Confidential information for activities pursuant to and related to the performance of the Contract. Contractor shall take all necessary steps to safeguard the confidentiality of such material or information in conformance with applicable state and federal law.
- The obligations set forth in this Section shall survive the termination of this Contract.
- E.3. State Ownership of Goods. The State shall have ownership, right, title, and interest in all goods provided by Contractor under this Contract including full rights to use the goods and transfer title in the goods to any third parties.
- E.4. Ownership of Software and Work Products.

a. Definitions.

- (1) "Contractor-Owned Software," shall mean commercially available software the rights to which are owned by Contractor, including but not limited to commercial "off-the-shelf" software which is not developed using State's money or resources.
- (2) "Custom-Developed Application Software," shall mean customized application software developed by Contractor solely for State.
- (3) "Rights Transfer Application Software," shall mean any pre-existing application software owned by Contractor or a third party, provided to State and to which Contractor will grant and assign, or will facilitate the granting and assignment of, all rights, including the source code, to State.
- (4) "Third-Party Software," shall mean software not owned by the State or the Contractor.
- (5) "Work Product," shall mean all deliverables exclusive of hardware, such as software, software source code, documentation, planning, etc., that are created, designed, developed, or documented by the Contractor exclusively for the State during the course of the project using State's money or resources, including Custom-Developed Application Software. If the deliverables under this Contract include Rights Transfer Application Software, the definition of Work Product shall also include such software. Work Product shall not include Contractor-Owned Software or Third-Party Software.

b. Rights and Title to the Software

- (1) All right, title and interest in and to the Contractor-Owned Software shall at all times remain with Contractor, subject to any license granted under this Contract.
- (2) All right, title and interest in and to the Work Product, and to modifications thereof made by State, including without limitation all copyrights, patents, trade secrets and other intellectual property and other proprietary rights embodied by and

arising out of the Work Product, shall belong to State. To the extent such rights do not automatically belong to State, Contractor hereby assigns, transfers, and conveys all right, title and interest in and to the Work Product, including without limitation the copyrights, patents, trade secrets, and other intellectual property rights arising out of or embodied by the Work Product. Contractor and its employees, agents, contractors or representatives shall execute any other documents that State or its counsel deem necessary or desirable to document this transfer or allow State to register its claims and rights to such intellectual property rights or enforce them against third parties.

(3) All right, title and interest in and to the Third-Party Software shall at all times remain with the third party, subject to any license granted under this Contract.

c. The Contractor may use for its own purposes the general knowledge, skills, experience, ideas, concepts, know-how, and techniques obtained and used during the course of performing under this Contract. The Contractor may develop for itself, or for others, materials which are similar to or competitive with those that are produced under this Contract.

E.5 State Furnished Property. The Contractor shall be responsible for the correct use, maintenance, and protection of all articles of nonexpendable, tangible personal property furnished by the State for the Contractor's use under this Contract. Upon termination of this Contract, all property furnished by the State shall be returned to the State in the same condition as when received, less reasonable wear and tear. Should the property be destroyed, lost, or stolen, the Contractor shall be responsible to the State for the fair market value of the property at the time of loss.

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

E.7 Prohibited Advertising or Marketing. The Contractor shall not suggest or imply in advertising or marketing materials that Contractor's goods or services are endorsed by the State. The restrictions on Contractor advertising or marketing materials under this Section shall survive the termination of this Contract.

E.8. Lobbying. The Contractor certifies, to the best of its knowledge and belief, that:

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

b. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

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

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

- E.9 Intellectual Property. Intellectual Property Indemnity. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims or suits which may be brought against the State concerning or arising out of any claim of an alleged patent, copyright, trade secret or other intellectual property infringement. In any such claim or action brought against the State, the Contractor shall satisfy and indemnify the State for the amount of any settlement or final judgment, and the Contractor shall be responsible for all legal or other fees or expenses incurred by the State arising from any such claim. The State shall give the Contractor notice of any such claim or suit, however, the failure of the State to give such notice shall only relieve Contractor of its obligations under this Section to the extent Contractor can demonstrate actual prejudice arising from the State's failure to give notice. This Section shall not grant the Contractor, through its attorneys, the right to represent the State of Tennessee in any legal matter, as provided in Tenn. Code Ann. § 8-6-106.
- E.10. Liquidated Damages In the event of a Contract performance or compliance failure by the Contractor, the State may, but is not obligated to address such Contract performance or compliance failure and/or assess damages ("Liquidated Damages") in accordance with Attachment B of the Contract. The State shall notify the Contractor of any amounts to be assessed as Liquidated Damages via the Control Memorandum process specified in Contract Section A.12. The Parties agree that due to the complicated nature of the Contractor's obligations under this Contract it would be difficult to specifically designate a monetary amount for a Contractor performance or compliance failure, as these amounts are likely to be uncertain and not easily proven. Contractor has carefully reviewed the Liquidated Damages contained in Contract Attachment C and agrees that these amounts represent a reasonable relationship between the amount and what might reasonably be expected in the event of a Contract performance or compliance failure, are a reasonable estimate of the damages that would occur from a Contract performance or compliance failure, and are not punitive. The Parties agree that although the Liquidated Damages represent the reasonable estimate of the damages and injuries sustained by the State due to the Contract performance or compliance failure, they do not include any injury or damage sustained by a third party. The Contractor agrees that the Liquidated Damages are in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or any other sections of this Contract.

The State is not obligated to assess Liquidated Damages as a result of a Contract performance or compliance failure before availing itself of any other remedy. In the event of multiple Contract performance or compliance failures, the Parties recognize that the cumulative effect of these Contract performance failures may exceed the compensation provided by Liquidated Damages. In that event, the State may choose to avail itself of any other remedy available under this Contract or at law or equity. The Parties further recognize that the State may not obtain both Liquidated Damages and Actual Damages for the same occurrence of a Contract performance or compliance failure.

Without regard to whether the State has imposed Liquidated Damages or pursued any other remedy due to any action or inaction by the Contractor, the State may impose a corrective action plan or similar measure through a Control Memorandum. Such measure is neither punitive nor related to any damages the State might suffer.

- E.11 Partial Takeover of Contract. The State may, at its convenience and without cause, exercise a partial takeover of any service that the Contractor is obligated to perform under this Contract, including any service which is the subject of a subcontract between Contractor and a third party (a "Partial Takeover"). A Partial Takeover of this Contract by the State shall not be deemed a breach of contract. The Contractor shall be given at least thirty (30) days prior written notice of a Partial Takeover. The notice shall specify the areas of service the State will assume and the date the State will be assuming. The State's exercise of a Partial Takeover shall not alter the Contractor's other duties and responsibilities under this Contract. The State reserves the right to

withhold from the Contractor any amounts the Contractor would have been paid but for the State's exercise of a Partial Takeover. The amounts shall be withheld effective as of the date the State exercises its right to a Partial Takeover. The State's exercise of its right to a Partial Takeover of this Contract shall not entitle the Contractor to any actual, general, special, incidental, consequential, or any other damages irrespective of any description or amount.

- E.12. Unencumbered Personnel. The Contractor shall not restrict its employees, agents, subcontractors or principals who perform services for the State under this Contract from performing the same or similar services for the State after the termination of this Contract, either as a State employee, an independent contractor, or an employee, agent, subcontractor or principal of another contractor with the State.
- E.13. Personally Identifiable Information. While performing its obligations under this Contract, Contractor may have access to Personally Identifiable Information held by the State ("PII"). For the purposes of this Contract, "PII" includes "Nonpublic Personal Information" as that term is defined in Title V of the Gramm-Leach-Bliley Act of 1999 or any successor federal statute, and the rules and regulations thereunder, all as may be amended or supplemented from time to time ("GLBA") and personally identifiable information and other data protected under any other applicable laws, rule or regulation of any jurisdiction relating to disclosure or use of personal information ("Privacy Laws"). Contractor agrees it shall not do or omit to do anything which would cause the State to be in breach of any Privacy Laws. Contractor shall, and shall cause its employees, agents and representatives to: (i) keep PII confidential and may use and disclose PII only as necessary to carry out those specific aspects of the purpose for which the PII was disclosed to Contractor and in accordance with this Contract, GLBA and Privacy Laws; and (ii) implement and maintain appropriate technical and organizational measures regarding information security to: (A) ensure the security and confidentiality of PII; (B) protect against any threats or hazards to the security or integrity of PII; and (C) prevent unauthorized access to or use of PII. Contractor shall immediately notify State: (1) of any disclosure or use of any PII by Contractor or any of its employees, agents and representatives in breach of this Contract; and (2) of any disclosure of any PII to Contractor or its employees, agents and representatives where the purpose of such disclosure is not known to Contractor or its employees, agents and representatives. The State reserves the right to review Contractor's policies and procedures used to maintain the security and confidentiality of PII and Contractor shall, and cause its employees, agents and representatives to, comply with all reasonable requests or directions from the State to enable the State to verify and/or procure that Contractor is in full compliance with its obligations under this Contract in relation to PII. Upon termination or expiration of the Contract or at the State's direction at any time in its sole discretion, whichever is earlier, Contractor shall immediately return to the State any and all PII which it has received under this Contract and shall destroy all records of such PII.

The Contractor shall report to the State any instances of unauthorized access to or potential disclosure of PII in the custody or control of Contractor ("Unauthorized Disclosure") that come to the Contractor's attention. Any such report shall be made by the Contractor within twenty-four (24) hours after the Unauthorized Disclosure has come to the attention of the Contractor. Contractor shall take all necessary measures to halt any further Unauthorized Disclosures. The Contractor, at the sole discretion of the State, shall provide no cost credit monitoring services for individuals whose PII was affected by the Unauthorized Disclosure. The Contractor shall bear the cost of notification to all individuals affected by the Unauthorized Disclosure, including individual letters and public notice. The remedies set forth in this Section are not exclusive and are in addition to any claims or remedies available to this State under this Contract or otherwise available at law.

- E.14. Federal Funding Accountability and Transparency Act (FFATA). This Contract requires the Contractor to provide supplies or services that are funded in whole or in part by federal funds that are subject to FFATA. The Contractor is responsible for ensuring that all applicable requirements, including but not limited to those set forth herein, of FFATA are met and that the Contractor provides information to the State as required.

The Contractor shall comply with the following:

- a. Reporting of Total Compensation of the Contractor's Executives.
- (1) The Contractor shall report the names and total compensation of each of its five most highly compensated executives for the Contractor's preceding completed fiscal year, if in the Contractor's preceding fiscal year it received:
- i. 80 percent or more of the Contractor's annual gross revenues from federal procurement contracts and federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and
 - ii. \$25,000,000 or more in annual gross revenues from federal procurement contracts (and subcontracts), and federal financial assistance subject to the Transparency Act (and subawards); and
 - iii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at <http://www.sec.gov/answers/execomp.htm>.)
- As defined in 2 C.F.R. § 170.315, "Executive" means officers, managing partners, or any other employees in management positions.
- (2) Total compensation means the cash and noncash dollar value earned by the executive during the Contractor's preceding fiscal year and includes the following (for more information see 17 C.F.R. § 229.402(c)(2)):
- i. Salary and bonus.
 - ii. Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.
 - iii. Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.
 - iv. Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.
 - v. Above-market earnings on deferred compensation which is not tax qualified.
 - vi. Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds \$10,000.
- b. The Contractor must report executive total compensation described above to the State by the end of the month during which this Contract is awarded.
- c. If this Contract is amended to extend the Term, the Contractor must submit an executive total compensation report to the State by the end of the month in which the term extension becomes effective.
- d. The Contractor will obtain a Data Universal Numbering System (DUNS) number and maintain its DUNS number for the term of this Contract. More information about obtaining a DUNS Number can be found at: <http://fedgov.dnb.com/webform/>

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

E.15 Survival. The terms, provisions, representations, and warranties contained in Sections D.11 (Records), D.19 (Hold Harmless), D.20 (HIPAA Compliance), E.2 (Confidentiality of Records), E.7 (Prohibited Advertising), E.9 (Intellectual Property) E.13 (Personally Identifiable Information), E.19 (Notification of Breach), E.21 (SSA Data), and E.25 (IRS Data) of this Contract shall survive the completion of performance, termination or expiration of this Contract.

E.16. Contractor Hosted Services and Confidential Data.

a. "Confidential State Data" is defined as data deemed confidential by State or Federal statute or regulation. The Contractor shall protect Confidential State Data as follows:

- (1) The Contractor shall ensure that all Confidential State Data is housed in the continental United States, inclusive of backup data.
- (2) The Contractor shall encrypt Confidential State Data at rest and in transit using the current version of Federal Information Processing Standard ("FIPS") 140-2 validated encryption technologies.
- (3) The Contractor's processing environment containing Confidential State Data shall be in accordance with at least one of the following security standards: (i) International Standards Organization ("ISO") 27001; (ii) Federal Risk and Authorization Management Program ("FedRAMP"); or (iii) American Institute of Certified Public Accountants ("AICPA") Service Organization Controls ("SOC") 2 Type II certified. The Contractor shall provide proof of current certification annually and upon State request.
- (4) The Contractor must comply with the State's Enterprise Information Security Policies. This document is found at the following URL:

<https://www.tn.gov/content/dam/tn/finance/documents/Enterprise-Information-Security-Policies-ISO-27002-Public.pdf>.

- (5) In the event that the operating system is an integral part of the application, the Contractor agrees to maintain Operating Systems at current, manufacturer supported versions. "Operating System" shall mean the software that supports a computer's basic functions, such as scheduling tasks, executing applications, and controlling peripherals.
- (6) The Contractor agrees to maintain the Application so that it will run on a current, manufacturer-supported Operating System. "Application" shall mean the computer code that supports and accomplishes the State's requirements as set forth in this Contract. The Contractor shall make sure that the Application is at all times fully compatible with a manufacturer-supported Operating System; the State shall not be required to run an Operating System that is no longer supported by the manufacturer.
- (7) If the Application requires middleware or database software, Contractor shall maintain middleware and database software versions that are at all times fully compatible with current versions of the Operating System and Application, to ensure that security vulnerabilities are not introduced.
- (8) With advance notice from the State, and no more than one (1) time per year the Contractor agrees to allow the State to perform logical and physical audits of the Contractor's facility and systems that are hosting Confidential State Data.
- (9) The Contractor must annually perform Penetration Tests and Vulnerability

Assessments against its Processing Environment. "Processing Environment" shall mean the combination of software and hardware on which the Application runs. "Penetration Tests" shall be in the form of software attacks on the Contractor's computer system, with the purpose of discovering security weaknesses, and potentially gaining access to the computer's features and data. The "Vulnerability Assessment" shall have the goal of defining, identifying, and classifying the security holes (vulnerabilities) in the Contractor's computer, network, or communications infrastructure. The Contractor shall allow the State, at its option, to perform Penetration Tests and Vulnerability Assessments on the Contractor's Processing Environment.

- b. Business Continuity Requirements. The Contractor shall maintain set(s) of documents, instructions, and procedures which enable the Contractor to respond to accidents, disasters, emergencies, or threats without any stoppage or hindrance in its key operations ("Business Continuity Requirements"). Business Continuity Requirements shall include:
 - (1) "Disaster Recovery Capabilities" refer to the actions the Contractor takes to meet the Recovery Point and Recovery Time Objectives defined below. Disaster Recovery Capabilities shall meet the following objectives:
 - i. Recovery Point Objective ("RPO"). The RPO is defined as the maximum targeted period in which data might be lost from an IT service due to a major incident: Four(4)Hours
 - ii. Recovery Time Objective ("RTO"). The RTO is defined as the targeted duration of time and a service level within which a business process must be restored after a disaster (or disruption) in order to avoid unacceptable consequences associated with a break in business continuity: Twelve (12) Hours
 - (2) The Contractor shall perform at least one Disaster Recovery Test every three hundred sixty-five (365) days. A "Disaster Recovery Test" shall mean the process of verifying the success of the restoration procedures that are executed after a critical IT failure or disruption occurs. The Disaster Recovery Test shall use actual State Data Sets that mirror production data, and success shall be defined as the Contractor verifying that the Contractor can meet the State's RPO and RTO requirements. A "Data Set" is defined as a collection of related sets of information that is composed of separate elements but can be manipulated as a unit by a computer. The Contractor shall provide written confirmation to the State after each Disaster Recover Test that its Disaster Recovery Capabilities meet the RPO and RTO requirements.
 - c. Upon State request, the Contractor shall provide a copy of all Confidential State Data it holds. The Contractor shall provide such data on media and in a format determined by the State.
 - d. Upon termination of this Contract and in consultation with the State, the Contractor shall destroy all Confidential State Data it holds (including any copies such as backups) in accordance with the current version of National Institute of Standards and Technology ("NIST") Special Publication 800-88. The Contractor shall provide a written confirmation of destruction to the State within ten (10) business days after destruction.
- E.17. Applicable Laws, Rules, Policies and Court Orders. The Contractor agrees to comply with all applicable federal and State laws, rules, regulations, sub-regulatory guidance, executive orders, TennCare waivers, and all current, modified or future Court decrees, orders or judgments applicable to the State's TennCare program. Such compliance shall be performed at no additional cost to the State.
- E.18. Business Associate. As the Contractor will provide services to TennCare pursuant to which the Contractor will have access to, receive from, create, or receive on behalf of TennCare Protected Health Information, or Contractor will have access to, create, receive, maintain or transmit on behalf of TennCare Electronic Protected Health Information (as those terms are defined under HIPAA and

HITECH), Contractor hereby acknowledges its designation as a business associate under HIPAA and agrees to comply with all applicable HIPAA regulations and the terms in the associated Business Associate Agreement.

- E.19. Notification of Breach and Notification of Suspected Breach. The Contractor shall notify TennCare's Privacy Office immediately upon becoming aware of and in no case later than forty-eight (48) hours after discovery of any incident, either confirmed or suspected, that represents or may represent unauthorized access, use or disclosure of encrypted or unencrypted computerized data that materially compromises the security, confidentiality, or integrity of enrollee PHI maintained or held by the Contractor, including any unauthorized acquisition of enrollee PHI by an employee or otherwise authorized user of the Contractor's system. This includes, but is not limited to, loss or suspected loss of remote computing or telework devices such as laptops, PDAs, Blackberrys or other Smartphones, USB drives, thumb drives, flash drives, CDs, and/or disks.
- E.20. Transmission of Contract Deliverables. All information or data that is necessary for one or more deliverable set forth in this Contract shall be transmitted between TennCare and Contractor via the data transfer method specified in advance by TennCare. This may include, but shall not be limited to, transfer through TennCare's SFTP system. Failure by the Contractor to transmit information or data that is necessary for a deliverable in the manner specified by TennCare, may, at the option of TennCare, result in liquidated damages as set forth on Contract Attachment B, hereto.
- E.21. Social Security Administration (SSA) Required Provisions for Data Security. The Contractor shall comply with limitations on use, treatment, and safeguarding of data under the Privacy Act of 1974 (5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget guidelines, the Federal Information Security Management Act of 2002 (44 U.S.C. §3541, *et seq.*), and related National Institute of Standards and Technology guidelines. In addition, the Contractor shall have in place administrative, physical, and technical safeguards for data.
- a. The Contractor shall specify in its agreements with any agent or subcontractor that will have access to data 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;
 - b. The Contractor shall not duplicate in a separate file or disseminate, without prior written permission from TennCare, the data governed by the Contract for any purpose other than that set forth in this Contract for the administration of the TennCare program. Should the Contractor propose a redisclosure of said data, the Contractor must specify in writing to TennCare the data the Contractor proposes to redisclose, to whom, and the reasons that justify the redisclosure. TennCare will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of the TennCare program.
 - c. The Contractor agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Contract.
 - d. The Contractor shall maintain a current list of the employees of such contractor with access to SSA data and provide such lists to TennCare at the start of the contract, subsequently at any time there are changes or upon request.
 - e. 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.
 - f. The Contractor shall provide appropriate training and ensure that its employees:
 - (1) properly safeguard PHI/PII furnished by TennCare under this Contract from loss, theft or inadvertent disclosure;
 - (2) understand and acknowledge that they are responsible for safeguarding this information at all times, regardless of whether or not the Contractor employee is at his or her regular duty station;
 - (3) ensure that laptops and other electronic devices/ media containing PHI/PII are encrypted and/or password protected;

- (4) send emails containing PHI/PII only if the information is encrypted or if the transmittal is secure; and,
- (5) limit disclosure of the information and details relating to a PHI/PII loss only to those with a need to know.

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

- g. Loss or Suspected Loss of Data–If an employee of the Contractor becomes aware of suspected or actual loss of PHI/PII, the Contractor must contact TennCare immediately upon becoming aware to report the actual or suspected loss. The Contractor must provide TennCare with timely updates as any additional information about the loss of PHI/PII becomes available.
If the Contractor experiences a loss or breach of said data, TennCare will determine whether or not notice to individuals whose data has been lost or breached shall be provided and the Contractor shall bear any costs associated with the notice or any mitigation.
- h. TennCare may immediately and unilaterally suspend the data flow under this Contract, or terminate this Contract, if TennCare, in its sole discretion, determines that the Contractor has: (1) made an unauthorized use or disclosure of TennCare SSA-supplied data; or (2) violated or failed to follow the terms and conditions of this Contract Section E.20.
- i. This Section further carries out Section 1106(a) of the Act (42 U.S.C. 1306), the regulations promulgated pursuant to that section (20 C.F.R. Part 401), the Privacy of 1974 (5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget ("OMB") guidelines, the Federal Information Security Management Act of 2002 ("FISMA") (44 U.S.C. 3541 et seq.), and related National Institute of Standards and Technology ("NIST") guidelines as outlined in the CMPPA and IEA governing this data,, which provide the requirements that the SSA stipulates that the Contractor must follow with regard to use, treatment, and safeguarding data in the event data is exchanged with a federal information system.
- j. Definitions
 - (1) "SSA-supplied data" or "data" as used in this section – information, such as an individual's social security number or income, supplied by the Social Security Administration to TennCare to determine entitlement or eligibility for federally-funded programs. This information is subject to provisions outlined in a Computer Matching and Privacy Protection Act Agreement (CMPPA) between SSA and the State of Tennessee, and Information Exchange Agreement (IEA) between SSA and TennCare.
 - (2) "Protected Health Information/Personally Identifiable Information" (PHI/PII) (45 C.F.R. 160.103; OMB Circular M-06-19) – Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.
 - (3) "Individually Identifiable Health Information"– information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
 - (4) "Personally Identifiable Information" – any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, Social Security Number, date and place of birth, mother's maiden name, biometric records, including any other personal information which can be linked to an individual.

- E.22. Medicaid and CHIP - The Contractor must provide safeguards that restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan:
- a) Purposes directly related to the administration of Medicaid and CHIP include:
 - 1) establishing eligibility;
 - 2) determining the amount of medical assistance;
 - 3) providing services for beneficiaries; and,
 - 4) conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to Medicaid or CHIP administration.
 - b) The Contractor must have adequate safeguards to assure that:
 - 1) Information is made available only to the extent necessary to assist in the valid administrative purposes of those receiving the information, and information
 - 2) received under 26 USC is exchanged only with parties authorized to receive that information under that section of the Code; and, the information is adequately stored and processed so that it is protected against unauthorized disclosure for other purposes.
 - c) The Contractor must have criteria that govern the types of information about applicants and beneficiaries that are safeguarded. This information must include at least--
 - 1) Names and addresses;
 - 2) Medical services provided;
 - 3) Social and economic conditions or circumstances;
 - 4) Contractor evaluation of personal information;
 - 5) Medical data, including diagnosis and past history of disease or disability
 - 6) Any information received for verifying income eligibility and amount of medical assistance payments, including income information received from SSA or the Internal Revenue Service;
 - 7) Income information received from SSA or the Internal Revenue Service must be safeguarded according to Medicaid and CHIP requirements;
 - 8) Any information received in connection with the identification of legally liable third party resources; and,
 - 9) Social Security Numbers.
 - d) The Contractor must have criteria approved by TennCare specifying:
 - 1) the conditions for release and use of information about applicants and beneficiaries;
 - 2) Access to information concerning applicants or beneficiaries must be restricted to persons or Contractor representatives who are subject to standards of confidentiality that are comparable to those of TennCare;

- 3) The Contractor shall not publish names of applicants or beneficiaries;
- 4) The Contractor shall obtain permission from a family or individual, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of medical assistance payment to an authorized individual or entity;
- 5) If, because of an emergency situation, time does not permit obtaining consent before release, the Contractor shall notify TennCare, the family or individual immediately after supplying the information.
- 6) The Contractor's policies must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials.
 - i) The Contractor shall notify TennCare of any requests for information on applicants or beneficiaries by other governmental bodies, the courts or law enforcement officials ten (10) days prior to releasing the requested information.
- 7) If a court issues a subpoena for a case record or for any Contractor representative to testify concerning an applicant or beneficiary, the Contractor must notify TennCare at least ten (10) days prior to the required production date so TennCare may inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.
- 8) The Contractor shall not request or release information to other parties to verify income, eligibility and the amount of assistance under Medicaid or CHIP, prior to express approval from TennCare.

E.23. Employees Excluded from Medicare, Medicaid or CHIP. The Contractor does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly employ, in the performance of this Contract, employees who have been excluded from participation in the Medicare, Medicaid, and/or CHIP programs pursuant to Sections 1128 of the Social Security Act.

E.24. Offer of Gratuities. By signing this contract, the Contractor signifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the federal General Accounting Office, federal Department of Health and Human Services, the Center for Medicare and Medicaid Services, or any other state or federal agency has or will benefit financially or materially from this Contract. This Contract may be terminated by TennCare as provided in Section D.6, if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, its agent, or employees.

E.25. Internal Revenue Service (IRS) Safeguarding Of Return Information:

- a) Performance - In performance of this contract, the contractor agrees to comply with and assume responsibility for compliance by his or her employees with the following requirements:
 - (1) This provision shall not apply if information received or delivered by the Parties under this Contract is NOT "federal tax returns or return information" as defined by IRS Publication 1075 and IRC 6103.
 - (2) All work will be done under the supervision of the contractor or the contractor's employees. The contractor and the contractor's employees with access to or who use FTI must meet the background check requirements defined in IRS Publication 1075.
 - (3) Any Federal tax returns or return information (hereafter referred to as returns or return information) made available in any format shall be used only for the purpose of carrying out the provisions of this contract. Information contained in such material will

be treated as confidential and will not be divulged or made known in any manner to any person except as may be necessary in the performance of this contract. Disclosure to anyone other than an officer or employee of the contractor will be prohibited.

- (4) All returns and return information will be accounted for upon receipt and properly stored before, during, and after processing. In addition, all related output will be given the same level of protection as required for the source material.
 - (5) The contractor certifies that the data processed during the performance of this contract will be completely purged from all data storage components of his or her computer facility, and no output will be retained by the contractor at the time the work is completed. If immediate purging of all data storage components is not possible, the contractor certifies that any IRS data remaining in any storage component will be safeguarded to prevent unauthorized disclosures.
 - (6) Any spoilage or any intermediate hard copy printout that may result during the processing of IRS data will be given to the agency or his or her designee. When this is not possible, the contractor will be responsible for the destruction of the spoilage or any intermediate hard copy printouts, and will provide the agency or his or her designee with a statement containing the date of destruction, description of material destroyed, and the method used.
 - (7) All computer systems receiving, processing, storing, or transmitting Federal tax information must meet the requirements defined in IRS Publication 1075. To meet functional and assurance requirements, the security features of the environment must provide for the managerial, operational, and technical controls. All security features must be available and activated to protect against unauthorized use of and access to Federal tax information.
 - (8) No work involving Federal tax information furnished under this contract will be subcontracted without prior written approval of the IRS.
 - (9) The contractor will maintain a list of employees authorized access. Such list will be provided to the agency and, upon request, to the IRS reviewing office.
 - (10) The agency will have the right to void the contract if the contractor fails to provide the safeguards described above.
- b) Criminal/Civil Sanctions
- (1) Each officer or employee of any person to whom returns or return information is or may be disclosed will be notified in writing by such person that returns or return information disclosed to such officer or employee can be used only for a purpose and to the extent authorized herein, and that further disclosure of any such returns or return information for a purpose or to an extent unauthorized herein constitutes a felony punishable upon conviction by a fine of as much as \$5,000 or imprisonment for as long as 5 years, or both, together with the costs of prosecution. Such person shall also notify each such officer and employee that any such unauthorized further disclosure of returns or return information may also result in an award of civil damages against the officer or employee in an amount not less than \$1,000 with respect to each instance of unauthorized disclosure. These penalties are prescribed by IRC sections 7213 and 7431 and set forth at 26 CFR 301.6103(n)-1.
 - (2) Each officer or employee of any person to whom returns or return information is or may be disclosed shall be notified in writing by such person that any return or return information made available in any format shall be used only for the purpose of carrying out the provisions of this contract. Information contained in such material shall be treated as confidential and shall not be divulged or made known in any

manner to any person except as may be necessary in the performance of the contract. Inspection by or disclosure to anyone without an official need to know constitutes a criminal misdemeanor punishable upon conviction by a fine of as much as \$1,000 or imprisonment for as long as 1 year, or both, together with the costs of prosecution. Such person shall also notify each such officer and employee that any such unauthorized inspection or disclosure of returns or return information may also result in an award of civil damages against the officer or employee [United States for Federal employees] in an amount equal to the sum of the greater of \$1,000 for each act of unauthorized inspection or disclosure with respect to which such defendant is found liable or the sum of the actual damages sustained by the plaintiff as a result of such unauthorized inspection or disclosure plus in the case of a willful inspection or disclosure which is the result of gross negligence, punitive damages, plus the costs of the action. These penalties are prescribed by IRC section 7213A and 7431.

- (3) Additionally, it is incumbent upon the contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a(i)(1), which is made applicable to contractors by 5 U.S.C. 552a(m)(1), provides that any officer or employee of a contractor, who by virtue of his/her employment or official position, has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than \$5,000.
- (4) Granting a contractor access to FTI must be preceded by certifying that each individual understands the agency's security policy and procedures for safeguarding IRS information. Contractors must maintain their authorization to access FTI through annual recertification. The initial certification and recertification must be documented and placed in the agency's files for review. As part of the certification and at least annually afterwards, contractors should be advised of the provisions of IRC Sections 7431, 7213, and 7213A. The training provided before the initial certification and annually thereafter must also cover the incident response policy and procedure for reporting unauthorized disclosures and data breaches. For both the initial certification and the annual certification, the contractor should sign, either with ink or electronic signature, a confidentiality statement certifying their understanding of the security requirements.

Inspection - The IRS and the Agency with 24 hour notice, shall have the right to send its officers and employees into the offices and plants of the contractor for inspection of the facilities and operations provided for the performance of any work with FTI under this contract. The IRS and Agency's right of inspection shall include the use of manual and/or automated scanning tools to perform compliance and vulnerability assessments of information technology (IT) assets that access, store, process or transmit FTI. On the basis of such inspection, specific measures may be required in cases where the contractor is found to be noncompliant with contract safeguards.

- E.26. Contractor Commitment to Diversity. The Contractor shall comply with and make reasonable business efforts to exceed the commitment to diversity represented by the Contractor's Response to 00600RFP 31865-00600 (Attachment 6.2, Section B.15) and resulting in this Contract.

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

IN WITNESS WHEREOF,

OPTUMRx, Inc.:

DocuSigned by:
Jeffrey Grosklags 1/25/2019

CONTRACTOR SIGNATURE **DATE**
Jeffrey Grosklags CFO

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF TENNCARE:

Stuart C. McWhorter 2/7/19

STUART C. MCWHORTER, COMMISSIONER **DATE**

DEFINITIONS AND ACRONYMS

Any terms and acronyms used in this Contract that are not defined herein shall have the meaning set forth in the TennCare Rules, the CoverRx statutory authority (T.C.A. § 56-57-101 et seq.) or the CoverKids statutory authority (T.C.A. § 71-3-1101 et seq., the State Child Health Plan under Title XXI of the Social Security Act State Children's Health Insurance Program, and the State Rules are 0620-05-01 et seq), respectively, as applicable based on the PBM Program being referred to. The following terms and acronyms used in this Contract shall have the meanings set forth below. In the event of a conflict between the definitions set forth herein and those contained in the TennCare Rules, the CoverRx statutory authority (T.C.A. § 56-57-101 et seq.), or the CoverKids statutory authority (T.C.A. § 71-3-1101 et seq., the State Child Health Plan under Title XXI of the Social Security Act State Children's Health Insurance Program, and the State Rules are 0620-05-01 et seq), respectively, the definitions set forth in this Contract shall govern.

1. **340B Pharmacy** - A pharmacy participating in a special drug discount program authorized by Section 340B of the Public Health Service Act. Participation is limited to the following types of providers: Consolidated Health Centers, AIDS clinics and drug programs, Black Lung Clinics, Federally Qualified Health Center Look-a-likes, Disproportionate Share Hospitals, Hemophilia treatment centers, Native Hawaiian health centers, Urban Indian clinics/638 tribal centers, Title X family planning clinics, STD clinics, TB clinics.
2. **834 File** – An ASC X12N file that contains 834 transactions. TennCare creates 834 files as part of the nightly enrollment cycle. Files are normally delivered to the receiving trading partner mid-morning each business day.
3. **834 Enrollee Transaction (834 Transaction)** – A series of 834 loop records that contain the enrollment information for a given TennCare member. The 834 Transaction may indicate current active enrollment or terminated enrollment.
4. **ACD** - Automatic Call Distributor (ACD) is a system or device that distributes incoming calls to a specific group of representatives and designated terminals.
5. **Actual Cost Avoidance** - The actual cost that TennCare would have paid for a TennCare claim had the claim not been eligible for reimbursement by TPL.
6. **Adverse Benefit Determination** – As defined in 42 C.F.R. §438.400(b), including but not limited to any of the following actions or proposed actions taken by Contractor:
 - (1) The denial or limited authorization of a requested benefit, including determinations based on:
 - (a) type or level of benefit,
 - (b) requirements for medical necessity,
 - (c) appropriateness, setting, or
 - (d) effectiveness of a covered benefit.
 - (2) The reduction, suspension, or termination of a previously authorized covered benefit.
 - (3) The denial, in whole or in part, of payment for a benefit.
 - (4) The failure to authorize and arrange provision of a benefit within TennCare agency-prescribed timeframes, and
 - (5) For a resident of a rural area with only one Contractor PBM Provider, the denial of an enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network.
 - (6) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.
7. **Appeal** – Synonymous with an enrollee request for a State fair hearing. CMS has determined that the provisions contained in 42 C.F.R. 438 subpart F, which require PAHPs to maintain an internal appeal system, and which require enrollee to exhaust the PAHP internal appeal process before being permitted to request a State fair hearing, are satisfied by the TennCare agency's requirement that Contractor comply with the "Reconsideration" phase of the TennCare appeal process. In accordance with CMS approval, the Contractor will not have an internal appeal process that enrollees are required to exhaust before they may request a TennCare appeal and attendant State fair hearing. The Contractor's "Reconsideration" (during

the TennCare appeal process) of its adverse benefit determination is deemed by CMS to satisfy the requirement for a PAHP-level appeal.

8. **Appeal System** – Synonymous with TennCare appeal process, with state fair hearing system, and state fair hearing process. References to Contractor Appeal System or Contractor Appeal Process refers to both (1) the processes the Contractor implements to comply with its state fair hearing process-related obligations such as timely issuance of a compliant NABD, timely compliance with the Reconsideration phase, timely compliance with TennCare-issued directives, etc., and (2) the processes the Contractor implements to collect, track and maintain the information gathered in accordance with the state fair hearing process.
9. **Ambulatory Pharmacy** - For TennCare Program purposes, and exclusive of TennCare Specialty Pharmacy services, this type of pharmacy is a chain drug store or independent pharmacy or any other entity licensed by the Tennessee Board of Pharmacy, or an entity duly licensed by any State Pharmacy Board, to dispense prescriptions directly to outpatient TennCare enrollees (other than by mail order) in any ambulatory setting. In order to be considered an ambulatory pharmacy, at least 75% of the pharmacy's prescription volume must consist of face to face interactions with customers. NCPDP Dispenser Class and Type "7" (Dispensing Physicians) are not eligible for enrollment as an Ambulatory Pharmacy.
10. **AMP** - Average Manufacturer Price is a reference drug price calculated by CMS. It is based on data provided by pharmaceutical manufacturers. This value is used to calculate Medicaid Drug Rebates for state Medicaid programs.
11. **AWP** - Average Wholesale Price is a reference price for prescription drug products. Pharmacy reimbursement can be calculated based on AWP minus a percentage. The AWP amount is provided by commercial publishers of drug pricing data such as First Data Bank or Thomson Medical Economics.
12. **Business Interruption** - Any disruption in operations that is equal to or longer than ten (10) minutes in duration.
13. **Clean Claim** - A claim received by the PBM for adjudication, and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the PBM.
14. **CHF** - Congestive Heart Failure is a condition in which the heart's function as a pump to deliver oxygen rich blood to the body is inadequate to meet the body's needs.
15. **CHIPRA** - Children's Health Insurance Program Reauthorization Act, a federal law.
16. **CMS** - The federal Centers for Medicare and Medicaid Services.
17. **Copay** – The amount certain TennCare, CoverRx and CoverKids should pay for certain Pharmaceutical Services in accordance with the TennCare waiver, CoverRx statutory authority (T.C.A. § 56-57-101 et seq.), and the CoverKids statutory authority (T.C.A. § 71-3-1101 et seq., the State Child Health Plan under Title XXI of the Social Security Act State Children's Health Insurance Program, and the State Rules are 0620-05-01 et seq.), respectively.
18. **Covered Services** – Covered Services differ by PBM Program as follows:
 - (a) For TennCare enrollees, this is a medication or service authorized under TennCare Rules 1200-13-13-04 and/or 1200-13-14.04 that has been prescribed for an eligible TennCare enrollee by an authorized prescriber, with reimbursement for covered medications by the TennCare Program contingent upon a prescription issued by a licensed provider. A link to the TennCare PDL and TennCare Pharmacy Manual can be found on the TennCare website;
 - (b) For CoverRx members, this is a medication or service authorized under T.C.A. § 56-57-101 et seq. that has been prescribed for an eligible CoverRx member by an authorized prescriber, with reimbursement for covered medications by the CoverRx Program contingent upon a prescription issued by a licensed provider. A link to the CoverRx CDL and CoverRx Pharmacy Manual can be found on the CoverRx website; and
 - (c) For CoverKids members, this is a medication or service authorized under T.C.A. § 71-3-1101 et seq., the State Child Health Plan Under Title XXI of the Social Security Act State Children's Health Insurance Program and State Rules 0620-05-01 et seq. that has been prescribed for an eligible CoverKids member

- by an authorized prescriber, with reimbursement for covered medications by the CoverKids Program contingent upon a prescription issued by a licensed provider. A link to the CoverKids PDL and CoverKids Pharmacy Manual will be provided on the CoverKids website prior to CoverKids Go Live.
19. **CoverKids Group One Children** - Enrollees who are members of families with incomes between two hundred and five percent (205%) and two hundred fifty five percent (255%) of the federal poverty level (FPL) as reported by the State to the Contractor for the coverage period.
 20. **CoverKids Group Two Children** - Enrollees who are members of families below two hundred and four percent (204%) of FPL as reported by the State to the Contractor for the coverage period.
 21. **CoverKids Member Handbook** - The Member Handbook that is approved by the State for Members of the CoverKids program.
 22. **CoverKids Provider** - An institution, facility, agency, person, corporation, partnership, or association approved by the State which accepts as payment in full for providing benefits the amounts paid pursuant to a provider agreement with the Contractor.
 23. **CoverRx Provider** - An institution, facility, agency, person, corporation, partnership, or association approved by the State which accepts as payment in full for providing benefits the amounts paid pursuant to a pharmacy provider agreement with the Contractor.
 24. **CSR** - Customer Service Representative is a person working in a Contractor's help desk/call center operation.
 25. **Complete Claim** – Any claim received by the PBM for adjudication where sufficient information has been provided to permit the claim to have been either denied or allowed
 26. **Data Dictionary** - A set of information describing the contents, format, and structure of a database and the relationship between its elements, used to control access to and manipulation of the database.
 27. **Data Mapping** – In simple terms, means to map source data fields to their related target data fields
 28. **DAW (Dispense as Written)** - A prescription that cannot be filled with a generic because the prescriber has indicated Dispense as Written on the prescription.
 29. **Disaster** - A negative event that significantly disrupts business operations for more than one (1) hour.
 30. **Disenrollment** - The discontinuance of a TennCare, CoverRx or CoverKids member's entitlement to receive Covered Services under the terms of this Contract, and deletion from the approved list of enrollees furnished by the State to the Contractor.
 31. **Dispensary** – A dispensing physician who dispenses medication to enrollees in his/her office.
 32. **DDI Phase** – Design, development and implementation phase of the process of creating Contractor's PBM systems to be used to provide services to the TennCare PBM Programs.
 33. **DEA Number** - A Drug Enforcement Agency (DEA) Number is a series of numbers assigned to a health care provider allowing them to write prescriptions for controlled substances. The DEA number is often used as a prescriber identifier.
 34. **Drug Efficacy Study Implementation (DESI) Drug** - A drug that has been designated as experimental or ineffective by the Food and Drug Administration (FDA).
 35. **DSS** - A decision support system is a database and query tool.
 36. **DUR** - Drug Utilization Review is program is to improve patient safety and care and to reduce overall drug costs. Medicaid DUR programs are required by the federal Omnibus Budget Reconciliation Act of 1990 to provide prospective claim edits retrospective analysis and educational programs.

37. **Eligible Individuals** - Persons who meet criteria for TennCare, CoverRx or CoverKids eligibility established by the State within its statutory authority as of the effective date of this Contract.
38. **Enrollment** - The date the Contractor enters the TennCare, CoverRx or CoverKids applicant's data into Contractor's core processing system.
39. **EMC** - Electronic Media Claims.
40. **Enrollee** - Any eligible individual who has enrolled in the TennCare Program, CoverRx Program, or the CoverKids Program in accordance with the rules and regulations of the applicable program. For purposes of the appeals system-related provisions herein, "Enrollee" means enrollee, enrollee-authorized representative, or someone with written consent to act on enrollee's behalf. (Enrollee is synonymous with Member, Participant or Recipient).
41. **Ethical and Religious Directives (often called the ERDs)** - means a document that offers moral guidance on various aspects of health care delivery and is based on a religious organization's theological and moral teachings.
42. **FAR** - Federal Acquisition Regulation
43. **FAQs** - Frequently Asked Questions.
44. **FDA** - Federal Drug Administration
45. **FIR** - Functional and Informational Requirements.
46. **FTE** - Full time equivalent position.
47. **FUL** - Current Federal Upper Limit price as listed by CMS.
48. **GCN** - Generic Code Number.
49. **Go Live** - The date and time upon which the Contractor assumes all PBM responsibility and functions for each of the TennCare PBM Programs from the previous TennCare PBM contractors.
50. **Grievance** - A complaint or an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision. See 42 C.F.R. §438.400(b).
51. **Grievance System** - The processes the Contractor implements to handle grievances, as well as the processes to collect and track information about them. See 42 C.F.R. §438.400(b).
52. **GSN** - Generic Sequence Number.
53. **Tennessee Medicaid provider number** - A unique identification number assigned by TennCare to a person or entity seeking to provide services for any TennCare program following the person's or entity's successful registration with the State through the TennCare Provider Registration Portal located at [add website link here]. A TennCare ID Number is required to submit a claim for reimbursement to the State for services provided to an enrollee of the TennCare, CoverRx or CoverKids Program.
54. **TennCare Record** - Any record, in whatever form, including but not limited to, medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution involving any TennCare PBM Program or any enrollees of such TennCare PBM Programs.

55. **HIPAA** - Health Insurance Portability and Accountability Act of 1996 which mandates the use of standards for the electronic exchange of health code data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payors (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of individually identifiable health care information.
56. **HITECH** – The Health Information Technology for Economic and Clinical Health Act which was enacted to improve health care quality, safety, and efficiency through the promotion of health information technology (HIT) and the electronic exchange of health information; to adopt an initial set of standards, implementation specifications, and certification criteria to enhance the interoperability, functionality, utility, and security of health information technology; and, to establish the capabilities and related standards that certified electronic health record (EHR) technology (Certified EHR Technology) shall need to include in order to, at a minimum, support the achievement of the proposed meaningful use by eligible professionals and eligible hospitals.
57. **Hot Site** - An alternative facility with the capability to readily assume responsibility for carrying out the activities carried out at the Contractor's main site.
58. **Incomplete Claim** – Any claim received by the PBM for adjudication that cannot either be denied or allowed due to insufficient information and/or documentation that is needed from the provider in order to allow or deny the claim.
59. **IVR or IVRU** - Interactive voice response unit is a telephone technology that allows a computer to detect voice and touch tones using a phone call and provide individualized system generated information for callers.
60. **IRS** - Drugs that are identical, related or similar (IRS) to drugs identified as less than effective (LTE) by the FDA.
61. **Limited English Proficiency (LEP)** - As defined at 42 CFR 438.10(a), means potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.
62. **Lock In** - A restrictive logic that limits claims at point of sale to selected prescribers or pharmacies. Members under this restriction are said to be "locked-in".
63. **Lock In Pharmacy** - The Pharmacy that shall be the exclusive provider for certain covered pharmacy services for enrollees chosen and assigned by the State.
64. **Long-Term Care Facility** - An institution which provides one of the following services: a nursing facility (NF); an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or a Home and Community-Based Services (HCBS) waiver program.
65. **Long Term Care Pharmacy Provider** – An entity licensed by the Tennessee Board of Pharmacy or duly licensed by any State Pharmacy board to dispense prescriptions to or for residents of a Long Term Care Facility.
66. **LTE** - Drugs that the FDA considers to be less than effective because there is a lack of substantial evidence of effectiveness for all labeled indications and for which there is no compelling justification for their medical need.
67. **MAC** - Maximum Allowable Cost.
68. **MAC List** – The list of certain prescription drugs and their respective "MAC" prices for which reimbursement shall be made to the Provider. MAC Lists are subject to periodic review by the State and/or the PBM and may be modified from time to time at the State's and/or the PBM's discretion. A link to current MAC rates is included on the TennCare PBM Program website
69. **MCO** – A managed care organization participating in the TennCare program.

70. **MEDD** - Morphine Equivalent Daily Dose
71. **Member** - Any eligible individual who has enrolled in the TennCare, CoverRx, CoverKids, or Optional Program in accordance with the TennCare Rules and Regulations, CoverRx statutory authority (T.C.A. § 56-57-101 et seq.), or the CoverKids statutory authority (T.C.A. § 71-3-1101 et seq.) and State Child Health Plan under Title XXI of the Social Security Act State Children's Health Insurance Program, respectively. (Member is synonymous with Enrollee, Participant or Recipient).
72. **Member Materials** – All materials that will be distributed to enrollees of the TennCare PBM Programs, including, but not limited to, member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, system generated letters and notices, and any other additional, but not required, materials and information provided to members designed to promote health and/or educate members.
73. **MMIS** – Medicaid Managed Information System
74. **NCPDP** - National Council of Prescription Drug Programs.
75. **NCPDP Code 41** – The current National Counsel for Prescription Drug Programs (NCPDP) version Code 41 (meaning "Submit Bill to Other Processor or Primary Payer") which is generated by the Contractor's POS system in response to a query by a pharmacy attempting to fill an enrollee's prescription that indicates the enrollee has other third party insurance (TPL) which causes TennCare to be the secondary, rather than the primary payor for that claim.
76. **NDC** - National Drug Code Number.
78. **NPI** - National Provider Identification Number - A HIPAA Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
78. **NTIS** - National Technical Information Service operated by the US Department of Commerce.
79. **Network** – A group of pharmacy providers contracted by the Contractor to perform specified services for the TennCare, CoverRx, CoverKids or Optional Programs. Some of these programs, such as TennCare and CoverKids, may have more than one (1) provider Network at a time, such as the CoverKids Ambulatory Network, CoverKids Specialty Network, CoverKids MTM Network, the CoverKids Ambulatory Network and the CoverKids Specialty Network.
80. **OBRA** - Omnibus Budget Reconciliation Act
81. **OTC** - Over-the-counter medications.
82. **Other Insurance** – For purposes of TPL, the term "Other Insurance" shall mean any health insurance an enrollee has in addition to the benefits he/she receives under the CoverKids Program.
83. **PA** - Prior Authorization - A program requirement where certain therapies must gain approval before payment can be authorized.
84. **Participant** - Any eligible individual who has enrolled in the TennCare, CoverRx, CoverKids, or Optional Program in accordance with the TennCare Rules and Regulations, CoverRx statutory authority (T.C.A. § 56-57-101 et seq.), or the CoverKids statutory authority (T.C.A. § 71-3-1101 et seq.) and State Child Health Plan under Title XXI of the Social Security Act State Children's Health Insurance Program, respectively. (Participant is synonymous with Member, Recipient or Enrollee).
85. **PDL** - Preferred Drug List.

- 86. **Peak Times** – For purposes of this Contract, the term “Peak Times” with regard to pharmacy operations shall mean the period of time from 7a.m. CST through 10 p.m. CST, seven (7) days a week.
- 87. **PHI** - Protected Health Information, as defined in HIPAA (45 C.F.R. §§ 160 and 164).
- 88. **POS** - Point-of-Sale.
- 89. **Prescriber** – An individual authorized by law to prescribe drugs for human consumption.
- 90. **Prescription Drug** - Pharmaceutical drug that legally requires a medical prescription to be dispensed
- 91. **Prescription Drug Coverage** - Health insurance or plan that helps pay for prescription drugs and medications
- 92. **Prevalent Language** - As defined at 42 CFR 438.10(a), means a non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient.
- 93. **Pro-DUR** - A point of sale claim edit to facilitate drug utilization review objectives.
- 94. **Quality Management/Quality Improvement (QM/QI)** - The ongoing process of assuring that the delivery of health care is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical knowledge, and the effort to assess and improve the performance of a program or organization. Quality Improvement includes quality assessment and implementation of corrective actions to address any deficiencies identified.
- 95. **RA** - Remittance Advice.
- 96. **Readily accessible** - As defined at 42 CFR 438.10(a), means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.
- 97. **Recipient** - Any eligible individual who has enrolled in the TennCare, CoverRx, CoverKids, or Optional Program in accordance with the TennCare Rules and Regulations, CoverRx statutory authority (T.C.A. § 56-57-101 et seq.), or the CoverKids statutory authority (T.C.A. § 71-3-1101 et seq.) and State Child Health Plan under Title XXI of the Social Security Act State Children's Health Insurance Program, respectively. (Recipient is synonymous with Member, Participant or Enrollee).
- 98. **Reconsideration** - mandatory component of the TennCare appeal process by which an MCC reviews and renders a decision affirming or reversing the adverse benefit determination at issue in the enrollee's request for a TennCare appeal. An MCC satisfies the plan-level requirements of 42 C.F.R. 438 Subpart F when the review includes all available, relevant, clinical documentation (including documentation which may not have been considered in the original review); is performed by a physician other than the original reviewing physician; and produces a timely written finding. See June 5, 2017, CMS letter from Jackie Glaze to Wendy Long, M.D., M.P.H.
- 99. **RFP** - Request for Proposal.
- 100. **Retro-DUR** - A post payment claims analysis to facilitate drug utilization review objectives.
- 101. **Specialty Drug** - Specialty Drug – A drug that is dispensed via the mail or shipping at least 51% of the time (not typically via retail distribution), does not appear on CMS' NADAC List, and meets at least two (2) of the following criteria:
 - 1. Greater than \$500 for a 30-day supply;
 - 2. Drug only approved for limited patient populations;
 - 3. Drug typically injected, infused or requires close monitoring by a physician or clinically trained individual; or
 - 4. Drug has limited availability, special dispensing and delivery requirements

and/or requires additional patient support.

102. **Specialty Pharmacy** - A pharmacy that dispenses specialty drugs only and is specialty only as its core business. The pharmacy must be a closed door practice, does not offer retail prescription drugs of any type to retail pharmacy customers, and not open to public walk-in prescription traffic.
103. **State** - The State of Tennessee, including, but not limited to, any entity or agency of the state, such as the Department of Finance and Administration (F&A), the Division of TennCare (TennCare), the TennCare Office of Inspector General (TennCare OIG), , the Medicaid Fraud Control Unit (MFCU), the Department of Mental Health (DMH), the Department of Children's Services (DCS), the Department of Health (DOH), the TennCare Oversight Division within the Department of Commerce and Insurance (C&I) and the Office of the Attorney General (AG).
104. **State Fair Hearing (SFH)** – The process set forth in subpart E of part 431 chapter IV, title 42 under which TennCare enrollees have the right to request a TennCare appeal and the attendant State fair hearing to contest Contractor-proposed Adverse Benefit Determinations. CoverKids enrollees do not have the right to a SFH, but may receive a CoverKids "Review". See 42 CFR §438.400(b).
105. **Step Therapy** - A program requirement to begin drug therapy with the most cost-effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary. The objectives are to control costs and minimize risks.
106. **STS** - Tennessee Strategic Technology Solutions
107. **Subcontract** - An agreement that complies with all applicable requirements of this Contract entered into between the Contractor and another organization or person to perform any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract, (e.g., marketing).
108. **Subcontractor** - Any organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract.
109. **System Interruption** - Any event that affects more than five percent (5%) of POS transactions and call center operations, or a data integrity issue that compromises the confidentiality of the system of data contained within the system.
110. **TCA** - Tennessee Code Annotated.
111. **TBI/TBI MFCU** - The Tennessee Bureau of Investigation's Medicaid Fraud Control Unit has the authority to investigate and prosecute (or refer for prosecution) violations of all applicable state and federal laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, the activities of providers of medical assistance in the state Medicaid program (TennCare), allegations of abuse or neglect of patients in health care facilities receiving payments under the state Medicaid program, misappropriation of patients' private funds in such facilities, and allegations of fraud and abuse in board and care facilities.
112. **Total Parenteral Nutrition (TPN)** - A compounded nutritional prescription for patients unable to gain nourishment through their gastrointestinal tract.
113. **UOM** - Unit of Measure.
114. **Vital Documents** – Vital Documents may include, but are not limited to, consent and complaint forms, intake and application forms with the potential for important consequences, notices pertaining to the reduction, denial, delay, suspension or termination of services, certain critical outreach documents and any other documents designated by the State. At a minimum, all Vital Documents shall be available in the Spanish language.

- 115. Warm Transfer**- A telecommunications mechanism in which the person answering the call facilitates transfer to a third party, announces the caller and issue, and remains engaged as necessary to provide assistance.
- 116. Wholesale Acquisition Cost (WAC)** - The manufacturer's published *catalog* or *list* price for a drug product to wholesalers. WAC does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions in price.
- 117. Working Hours** – Working Hours are Monday through Friday from 8:00 a.m. to 4:30 p.m. Central Time (CT), except on official State holidays.

ATTACHMENT B

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	
EDISON VENDOR IDENTIFICATION NUMBER:	

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

CONTRACTOR SIGNATURE

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. Attach evidence documenting the individual's authority to contractually bind the Contractor, unless the signatory is the Contractor's chief executive or president.

PRINTED NAME AND TITLE OF SIGNATORY

DATE OF ATTESTATION

ATTACHMENT C

LIQUIDATED DAMAGES

In the event of a Contract performance or compliance failure by Contractor and such Contract performance failure is not included in the following table with an associated Liquidated Damage amount, the parties hereby agree that the State may choose one of the following courses of action in order to obtain redressability for such Contract performance failure: (1) the State may assess actual damages resulting from the Contract performance or compliance failure against the Contractor in the event that such actual damages are known or are reasonably ascertainable at the time of discovery of such Contract performance or compliance failure or (2) if such actual damages are unknown or are not reasonably ascertainable at the time of discovery of the Contract performance or compliance failure, the State may (a) require the Contractor to submit a corrective action plan to address any such Contract performance or compliance failure and (b) assess a Liquidated Damage against Contractor for an amount that is reasonable in relation to the Contract performance failure as measured at the time of discovery of the Contract performance or compliance failure. In the event that the State chooses to assess a Liquidated Damage for a Contract performance or compliance failure according to the immediately preceding sentence, in no event shall such Liquidated Damage be in excess of \$1,000 per calendar day for any single Contract performance or compliance failure.

TennCare may elect to apply the following Liquidated Damages remedies in the event the Contractor fails to perform its obligations under this Contract in a proper and/or timely manner. Upon determination by TennCare that the Contractor has failed to meet any of the requirements of this Contract in a proper and/or timely manner, TennCare will notify the Contractor in writing of the performance or compliance failure and of the potential Liquidated Damages to be assessed. Should the performance or compliance failure remain uncorrected for more than thirty (30) calendar days from the date of the original notification of the performance or compliance failure by TennCare, TennCare may impose an additional Liquidated Damage of Five Hundred Dollars (\$500) per day from the date of the original notification to Contractor until said performance or compliance failure is resolved.

All Liquidated Damages remedies set forth in the following table may, at TennCare's election, be retroactive to the date of the initial occurrence of the failure to comply with the terms of the Contract as set forth in the notice of deficiency from TennCare and may continue until such time as the TennCare Deputy Commissioner, or the Deputy Commissioner's representative, determines the performance or compliance failure has been cured.

If Liquidated Damages are assessed, TennCare shall reduce the amount of any payment due to the Contractor in the next invoice by the amount of damages. In the event that damages due exceed the amount TennCare is to pay to Contractor in a given payment, TennCare shall invoice Contractor for the amount exceeding the amount payable to Contractor, and such excess amount shall be paid by Contractor within thirty (30) calendar days of the invoice date. In situations where the Contractor wishes to dispute any Liquidated Damages assessed by TennCare, the Contractor must submit a written notice of dispute, including the reasons for disputing the Liquidated Damages, to the TennCare Deputy Commissioner or the Deputy Commissioner's representative within thirty (30) calendar days of receipt of the notice from TennCare containing the total amount of damages assessed against the Contractor. If the Contractor fails to timely dispute a Liquidated Damages assessment as set forth herein, such failure shall constitute a bar to the Contractor seeking to have the assessment amount overturned in a forum or court of competent jurisdiction.

Liquidated Damages will apply in the below Contract performance or compliance failures. Contractor acknowledges that the actual damages likely to result from breach of the below contract performance or compliance failures are difficult to estimate and may be difficult for the State to prove. The parties intend that the Contractor's payment of assessed Liquidated Damages will compensate the State for breach by the Contractor obligations under this Contract. Liquidated Damages do not serve as punishment for any breach by the Contractor.

	<u>PROGRAM ISSUES</u>	<u>DAMAGE</u>
1.	Failure by the Contractor to meet the standards for privacy, security, and confidentiality of individual data as evidenced by a breach of the security per Section E. 2, E.21, E.22 and E.25	The damage that may be assessed shall be one thousand dollars (\$1,000.00) per affected member per occurrence.

2.	<p>Failure by the Contractor to execute the appropriate agreements to effectuate transfer and exchange of 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 E.18. and Business Associate Agreement between the parties)</p>	<p>The damage that may be assessed shall be one thousand dollars (\$1,000.00) per affected member per occurrence.</p>
3.	<p>Failure by the Contractor to seek express written approval from TennCare prior to the use or disclosure of 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 E.18 and Business Associate Agreement between the parties)</p>	<p>The damage that may be assessed shall be one thousand dollars (\$1,000.00) per affected member per occurrence.</p>
4.	<p>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 suspected breach per Sections (See E.18 and Business Associate Agreement between the parties)</p>	<p>The damage that may be assessed shall be one thousand dollars (\$1,000.00) per affected member per occurrence.</p>
5.	<p>Failure by the Contractor to comply with any approved DPRCCPS Plan or BCCP Plan (DPRCCPS: Section A.31) (BCCP: Section A.32)</p>	<p>The damage that may be assessed, in the State's discretion, shall not exceed ten thousand dollars (\$10,000) per calendar day Contractor is non-compliant with its approved DPRCCPS Plan or its BCCP Plan</p>
6.	<p>Failure by the Contractor to comply with a Control Memorandum and Control Directive (CM/CD) or Corrective Action Plan (CAP). (Section E.10 and Section A.5)</p>	<p>The damage that may be assessed shall not exceed two thousand dollars (\$2,000.00) per calendar day for each separate failure to comply with a CM/CD or CAP until compliance is met.</p> <p>If the Contractor fails to comply with the CM/CD or CAP for more than thirty (30) calendar days from the date of issuance of the CM/CD or CAP, TennCare may assess an additional two thousand dollars (\$2,000) per calendar day until the Contractor complies with the CM/CD or CAP.</p>
7.	<p>Failure by the Contractor to produce eight hundred (800) member profiles per month, or a minimum of two thousand four hundred (2,400) member profiles per quarter, and distribute to clinical reviewers for review and determination of appropriate interventions to be taken.</p> <p>Monthly member profile reviews shall be completed and results/interventions</p>	<p>For member profiles, the damage that may be assessed shall be \$100 for each member profile less than the required 2,400 profiles for each quarter.</p> <p>For provider profiles, the damage that may be assessed shall be \$100 assessed for each letter or other approved, documented intervention less than the required 2,400 for each quarter.</p>

	<p>distributed to prescribers within sixty (60) days of the end of the month.</p> <p>(Section A.45.a.1.)</p> <p>The Contractor shall produce 2,400 provider profiles per quarter and determine appropriate interventions to address any potential problems identified during profile review. These interventions shall include at a minimum mailings sent to prescribers or pharmacy providers.</p> <p>Quarterly provider profile reviews shall be completed and results/interventions distributed to prescribers within ninety (90) days of the end of the quarter.</p> <p>(Section A.45.a.1.)</p>	
<p>8.</p>	<p>Failure by the Contractor to load all outbound 834 files from TennCare to the Contractor's data base within twenty-four (24) hours of receipt from TennCare. This requirement includes any 834 transactions that must be handled manually by the Contractor.</p> <p>(Section A.41.c, A.65.b)</p>	<p>The damage that may be assessed shall not exceed ten-thousand dollars (\$10,000) per calendar day, or any part thereof, beyond the first twenty-four (24) hours, that any outbound 834 files are not properly loaded into the Contractor's database</p>
<p>9.</p>	<p>Failure by the Contractor to satisfactorily complete all implementation actions and requirements prior to the TennCare, CoverRx, and CoverKids Go-Live dates and in accordance with the approved TennCare, CoverRx, and CoverKids Implementation Schedules.</p> <p>(Sections A.41, A.55, A.63)</p>	<p>The damage that may be assessed shall be ten thousand dollars (\$10,000.00) for each calendar day Go-Live of the TennCare Program is delayed past the date set out in A.40 for Go-Live of the TennCare program, A.53 for Go-Live of the CoverRx program, and A.61 for Go-Live of the CoverKids program.</p>
<p>10.</p>	<p>Failure by the Contractor to maintain provider agreements in accordance with Section</p> <p>(Section A.10).</p>	<p>The damage that may be assessed shall be \$2,500 per provider agreement found to be non-compliant with the requirements outlined in this Contract.</p>
<p>11.</p>	<p>Failure by the Contractor to present for TennCare approval remedies for all disputes within ninety (90) days of dispute.</p> <p>(Section A.43.e, A.57.j, A.73.k)</p>	<p>The damage that may be assessed shall be \$1,000 per calendar day past ninety (90) calendar days of dispute.</p>

12.	Failure by Contractor to start accruing interest on the date stipulated in the individual supplemental rebate agreements (Section A.43.e, A.57.j, A.73.k)	The damage that may be assessed shall be \$1,000 for every non-compliant invoice issued.
13.	Failure by the Contractor to generate and issue quarterly Rebate invoices. (Section A.43.e, A.57.j, A.73.k)	The damage that may be assessed shall be \$1,000 per invoice per calendar day an invoice is overdue.
14.	Failure by the Contractor to ensure that written past-due notifications are sent to Drug Manufacturers within five (5) calendar days of the delinquent date. (Section A.43.e, A.57.j, A.73.k)	The damage that may be assessed if the Contractor fails to send notice shall be \$100 per past-due notification not sent within five (5) calendar days of the delinquent date.
15.	Failure by the Contractor to respond to all reconsideration requests within one (1) business day, or to supply TennCare with all pertinent information pertaining to reconsideration requests within two (2) business days. (Section A.46.c, A.77.c)	The damage that may be assessed shall be \$200 per occurrence of failure to supply all pertinent information within two (2) business days.
16.	Failure by the Contractor to ensure that collection letters are sent to pharmacies that maintain an accounts-payable balance to the State greater than ninety (90) days. These notices shall be sent within five (5) business days of becoming ninety (90) days old. Contractor shall provide TennCare with a monthly report of notices sent. Reports are due monthly, ten (10) business days after end of month of reporting period. (Sections A.42.b, A.56.c, A.72.b, A. 72.c)	The damage that may be assessed shall be \$100 per provider notice per month if Contractor fails to send a collection letter within the required timeframe. .
17.	Failure by the Contractor to mail checks and remittance advices to pharmacy providers each week on Fridays, with the exception of holiday weeks. With notice, holiday production shall not delay the process by more than two (2) business days. TennCare shall be notified no later than two (2) business days of any systems or operational issues that may impact disbursements by the prescribed timelines. For checks to be issued on Friday, the Contractor shall deliver the "All Transactions" and "All Payments" files to the State, in an electronic media suitable to the State, by 10:00 a.m. CST, on Thursday of each week. (Sections A.42.b, A.56.b, and A.72. b.)	The damage that may be assessed shall be (\$2,000) per business day, per failure of the Contractor to (i) mail a check or remittance advice timely, (ii) failure to timely notify TennCare of a delay in mailing checks and remittance advices within two (2) business days, or (iii) to send to the State the "All Transactions" and "All Payments" as required by the contract. In each case, damages may be assessed per business day, per occurrence until the applicable requirement is met.
18.	Failure by the Contractor to pay within fifteen (15) calendar days of receipt one-hundred	The damage that may be assessed shall be one-thousand dollars (\$1,000) per

	<p>percent (100%) of all clean claims submitted by network and non-network pharmacy providers through POS and batch electronic claims submission.</p> <p>(Sections A.42.b, A.56.b, and A.72.b.)</p>	<p>calendar day, per occurrence of payment to pharmacy providers for clean claims exceeding fifteen (15) calendar days from the date of claim submission.</p>
19.	<p>Failure by the Contractor to comply with any TennCare PBM Program general or Key Staff requirements, including failure by the Contractor to have replacement in place within sixty (60) days of vacancies, unless TennCare grants an exception to the requirement and failure by the Contractor to provide copies of current Tennessee licenses for key staff.</p> <p>(Section A.7)</p>	<p>The damage that may be assessed shall be one thousand dollars (\$1,000.00) per calendar day, per occurrence. If the Contractor fails to comply with the Key Staff requirements for more than thirty (30) days, the damage that may be assessed shall be two thousand (\$2,000) per calendar day, per occurrence.</p> <p>For Key Staff vacancies, the damage that may be assessed shall be \$2,500 per month in addition to the salary of the position being withheld from the monthly payment. Calculation of the damages may begin on the sixty-first day following the vacancy of the position and may continue until monthly until the position is filed.</p> <p>For licenses, the damage that may be assessed shall be \$2,500 per week per employee, and may continue until receipt of the licensure verification by TennCare.</p>
20.	<p>TennCare-related Enrollee Appeals. Failure to confer a timely response to a request for Prior Authorization in accordance with §1927(d)(5) of the Social Security Act, 42 CFR 438.3(s)(6), and 42 CFR 438.210. (TennCare: A.46.d)</p>	<p>TennCare may assess damages amounting to \$500 for each day PBM is in default for each occurrence.</p>
21.	<p>TennCare-related Enrollee Appeals. Failure to confer a timely and content-compliant Notice of Adverse Benefit Determination in accordance with 42 CFR 438 Subpart F. (TennCare: A.46.d and A.51)</p>	<p>TennCare may assess damages amounting to \$500 for each day PBM is in default for each occurrence</p>
22.	<p>TennCare-related Enrollee Appeals. Failure to confer a timely and complete response to an <i>On Request Report</i> instructing PBM to determine whether a request for TennCare appeal warrants expedited resolution. (TennCare: A.46.d)</p>	<p>TennCare may assess damages amounting to \$500 for each day PBM is in default for each occurrence.</p>
23.	<p>TennCare-related Enrollee Appeals. Failure to confer a timely and complete response to an <i>On Request Report</i> instructing PBM to conduct Reconsideration of the PBM Adverse Benefit Determination. The Reconsideration response must contain the written medical review, the</p>	<p>TennCare may assess damages amounting to \$500 for each day PBM is in default for each occurrence.</p>

	PBM's Reconsideration decision and all information on which the decision was based.	
24.	<p>TennCare-related Enrollee Appeals. Failure to provide a timely and complete response to a TennCare request for appeal-related documentation including:</p> <ul style="list-style-type: none"> • prior authorization requests and decisions, • notices of ABD issued to enrollee, • Clinical Criteria or other guidelines forming the basis for PBM's ABD, • enrollee medical records and prescription history considered by the PBM in its PA or Reconsideration determination, • enrollee medical records submitted in relation to the PA or TennCare appeal request, • Medical Necessity reviews conducted by PBM in relation to the PA or Reconsideration request, and • Any other information related to the benefit under dispute. <p>(TennCare: A.46.d)</p>	TennCare may assess damages amounting to \$500 for each day PBM is in default for each occurrence.
25.	<p>TennCare-related Enrollee Appeals. Identification of a systemic failure of PBM's internal appeal system, as evidenced by PBM's failure to meet compliance requirements for any aspect of the appeal system in over 20% of appealed cases during a 60-day period</p> <p>(TennCare: A.46.d)</p>	TennCare may assess damages amounting to \$1,500 for each day PBM is in default until a TennCare-approved corrective action plan is fully implemented by the PBM.
26.	<p>Failure to maintain a grievance and appeal system as required by TennCare Rules, the provisions contained in the contract, and applicable provisions of 42 CFR 438 Subpart F.</p> <p>(TennCare: A.46.d)</p>	TennCare may assess damages amounting to \$500 for each day PBM is in default for each occurrence
27.	<p>Failure to timely authorize and arrange provision of a benefit or medication directed by TennCare. "Timely" means as quickly as the enrollee's condition requires, but no later than within 72 hours of the date the directive was issued.</p> <p>(TennCare: A.46.d)</p>	TennCare may assess damages amounting to \$500 for each day PBM is in default for each occurrence
28.	<p>Failure to timely authorize and arrange provision of a benefit approved by the PBM following Reconsideration. "Timely" means as</p>	TennCare may assess damages amounting to \$500 for each day PBM is in default for each occurrence.

	quickly as the enrollee's condition requires, but no later than within 72 hours of receiving the approval decision. (TennCare: A.46.d)	
29.	Failure to authorize reimbursement pursuant to a TennCare directive within 72 hours of the date the directive was issued. (TennCare: A.46.d)	TennCare may assess damages of \$500 per day for each day PBM is in default for each occurrence.
30.	Failure to submit an expedited appeal request to TennCare within one (1) business day. (TennCare: A.46.d)	TennCare may assess damages of \$500 per day for each day PBM is in default for each occurrence.
31.	Failure to submit a standard appeal request to TennCare within five (5) business days. (TennCare: A.46.d)	TennCare may assess damages of \$500 per day for each day PBM is in default for each occurrence.
32	Failure to provide sufficient staff, facilities and technology so calls to the Enrollee Initiated PA Unit are answered within thirty (30) seconds on at least twenty-seven (27) days per month, and the abandoned calls do not exceed two percent (2%) on more than three (3) days per month. (TennCare: A.46.e.8)	TennCare may assess damages of \$500 per day for each day PBM is in default for each occurrence.
33	Failure to have appropriate staff member(s) attend on-site meetings as requested and designated by TennCare. (Section A.23.a)	\$1,000 per appropriate staff person per meeting as requested by TennCare
34	Failure to have a backup telephone and fax system in place that shall operate in the event of any interruption in operations lasting 10 (ten) minutes or longer so access to the Prior Authorization Unit by telephone and fax is not disrupted. Failure to notify the State within one (1) hour of the time when the Contractor knows or should have known of a system or business interruption that is ten (10) minutes or longer in duration. (Section A.46.a.8)	TennCare may assess damages of \$50,000 per occurrence.

<p>35</p>	<p>Accurately produce and deliver all reports according to the date and frequency required in the Contract.</p> <p>(Sections A.23.a, A.61)</p>	<p>A maximum of one hundred dollars (\$100.00) for each day following the date that a reporting error is discovered in which the corrected report is not delivered.</p> <p>A maximum of five hundred dollars (\$500.00) for each day for each report the Contractor fails to deliver by the date or frequency specified in the Contract.</p> <p>A maximum of five hundred dollars (\$500.00) for each day that the Contractor fails to deliver an ORR report.</p>
<p>36</p>	<p>Provide timely and complete notice as required by Contract Section A.33.</p> <p>(Section A.33)</p>	<p>A maximum of fifty thousand dollars (\$50,000.00) for each failure of the Contractor to notify the State or provide the written documentation and Corrective Action Plan as required by Contract Section A.33.</p>
<p>37</p>	<p>The Contractor shall be responsible to ensure that TennCare is the payor of last resort in all situations where an enrollee has other health insurance coverage (Other Insurance), and to ensure that all COB (Coordination of Benefits) claims are being adjudicated only when Other Insurance has been exhausted first. The Contractor shall obtain current information regarding enrollees' Other Insurance in addition to TennCare, and perform daily updates to a third party liability (TPL) file.</p> <p>(Sections A.42.d.13 and A.72.d.25)</p>	<p>If the Contractor allows a claim(s) to be adjudicated with TennCare as the sole payor when Other Insurance existed and a valid TPL segment was provided by the State to the Contractor within at least two (2) business days prior to the Contractor adjudicating the claim, Liquidated Damages in the amount of up to 10% of the amount paid to pharmacy by the State.</p> <p>If the Contractor allows a claim(s) to be adjudicated with TennCare as the sole payor when Other Insurance existed, and the valid TPL segment is not found on the Contractor's TPL file, but is found on the State's TPL file. Liquidated Damages in the amount of up to 10% of the amount paid to pharmacy by the State .</p>

TennCare Management Reporting Requirements

	TennCare Report Name	Specific Content	Frequency	Distribution
1	Financial summary with change trend (Executive)	Executive Dashboard Metrics: Summary of Pharmacy Eligible enrollee and Utilizer Cost/Count, PMPM, PUPM	Monthly	Chief Pharmacy Director
2	Utilization statistics	Brand/Generic Utilization by claim and amount paid	Monthly	Chief Pharmacy Director
3	Claim processing	Volume, processing time and other statistics to be reviewed by Contractor (abnormalities to be reported to the State)	Daily	Chief Pharmacy Director
4	Pharmacy Drug Spend	Spend by Category and Drug	Monthly	Chief Pharmacy Director
5	Federal Rebate and Supplemental Rebate data	By drug, with details included on multiple worksheets to drill down to all drugs and categories	Quarterly	Rebate Analytics Manager
6	Pre-Invoice Summary	Quarterly Pre-Invoice Summary data file must be presented to designated State staff for Review/Validation/Accuracy/Approval including FFS, MCO, Supplemental and Diabetic Supply Invoices prior to submitting invoices to Manufacturers and completion of invoice cycle for accuracy.	Quarterly	Rebate Analytics Manager
7	Rebate Invoicing	Files should contain specific information and in specified format as required by the State. Provide State staff with electronic copy of Invoices for FFS, MCO, Supplemental and Diabetic Supply upon completion before invoices are available to Manufacturers.	Quarterly	Rebate Analytics Manager

	TennCare Report Name	Specific Content	Frequency	Distribution
8	Delinquent Rebate Payment Notices	Electronic copy of written notifications sent to Drug Manufacturers concerning forty day (45) past due rebate payments for undisputed account balances within fifty (50) days after the original invoice date. Electronic copy of written notifications sent to Drug Manufacturers concerning seventy five (75) past due rebate payments for undisputed account balances within eighty (80) days after the original invoice date. Electronic copy of written notifications sent to Drug Manufacturers concerning seventy five (75) past due undisputed account balances within ninety (90) days after the original invoice date.	As needed 45 ,75 and 90 days after each quarterly rebate payment cycle	Rebate Analytics Manager
9	CMS 64 9R	Expenditures for the Federal and Supplemental Rebates	Quarterly	Rebate Analytics Manager
10	Rebate Postmark Date	Submission Date of Invoice	Quarterly	Rebate Analytics Manager
11	Fire-Account Receivable	Account Balance: Billed, Collected, Adjusted and Balance Due by Quarter, Calendar and Fiscal Year	Quarterly	Rebate Analytics Manager

	TennCare Report Name	Specific Content	Frequency	Distribution
12	Drug Rebate Dispute Data / Rebate Dispute Resolution	<p>Report displaying all outstanding disputes should be submitted to the State in format requested below for review and approval prior to finalizing adjustments. Documentation shall be comprised of:</p> <ol style="list-style-type: none"> 1. All correspondence received from Manufacturer 2. Product Information in electronic format 3. Invoice Before Adjustments (Excel format only) 4. Claim Level Detail (Excel format only) 5. Dispute Resolution Proposal 6. Invoice After Adjustments (Excel format only) 7. Adjustment Report (Excel format only) <p>Provide any and all appropriate, accurate, and balanced pharmacy claim level detail (CLD) needed to resolve or avoid any Medicaid or Supplemental rebate disputes.</p> <p>Within ninety (90) Days of dispute, the contractor shall present the State with an analysis of why monies were disputed and remedies for resolution.</p>	Daily, Weekly, Monthly	Rebate Analytics Manager
13	Delinquent Rebate Payment Interest Accrual	Provide rebate reports that contain delinquent payments for Manufacturer undisputed account balance and interest for Supplemental and Federal rebates.	Quarterly	Rebate Analytics Manager
14	Claim Processing Exclusion	Report indicating number of claims excluded from Invoice process, (omitted provider id, hcpcs) etc., specifying category by type and monetary value.	Weekly/Monthly	Rebate Analytics Manager
15	340B Exclusion	Report indicating claims excluded from Invoice process, (omitted Covered Entities) Not allowing dual rebate collection	Weekly	Rebate Analytics Manager
16	Labeler Account Balance	Manufactures outstanding Rebate account balance	Quarterly	Rebate Analytics Manager
17	PDL Compliance (Drug Formulary)	By Provider and Specialty	Monthly	Clinical Director

	TennCare Report Name	Specific Content	Frequency	Distribution
18	Prior Authorization	Number of requests, number of approvals, number of denials. number of cancellations, number of interventions with Turn Around Time (TAT);	Monthly	Data Analytics Manager
19	Grievance(Appeals)	Appeal volume, disposition and aging to be reviewed by Contractor daily and reviewed with appropriate State personnel quarterly (abnormalities to be reported to the State immediately).	Daily/Quarterly	Clinical Director
20	Pharmacy Lock-in	Current list of all individuals included on TennCare's Lock-in List, Escalated List, Arrested List and Convicted List. To Include those with current eligibility, termed eligibility and also those who are not listed with PBM's system	As needed	Operations Director
21	Specialty Drug	Claims paid for specialty drugs for date ranges requested by the State. Input to be variable, based on current list of products considered "Specialty" drugs, with ability to add or delete products and drug categories.	As needed	Operations Director
22	Compounded Prescription	Claims paid for compounded drugs for date ranges requested by the State. With each ingredient listed in one line, with each ingredient's information concatenated into one cell, separated by "/" characters (for example, all NDC's for each product in one cell, all DRUG NAME's for each product into another cell)	As needed	Operations Director
23	Clinical Initiative	Gauge the effectiveness of various clinical initiatives, movement of market share within given therapeutic categories		Clinical Director
24	On Request Reports	To assist in managing the pharmacy benefit for TennCare enrollees	As needed	Pharmacy Team
25	Top 25 Drugs	Rank Drugs by Cost and Count Compared with previous week ranking	Weekly/Monthly	Data Analytics Manager
26	Enrollee Paid Copay	Enrollee Count and Utilizing with Co-Pay indicator <> 00, Total paid by Age Range with percentage of Utilizer paid	Monthly	Data Analytics Manager
27	Emergency Supply Aggregate	Monthly listing of all claims paid, submitted by pharmacy as "3-Day Emergency Supply".	Monthly	Operations Director

	TennCare Report Name	Specific Content	Frequency	Distribution
28	Batch Claim Operations	Data entry volumes and types of transactions summaries	Daily/Weekly/Monthly	Data Analytics Manager
29	Help Desk and Prior Authorization (PA) Activity	Call Center Service Level Agreement for calls, answer speed and abandoned rate. PA request processed, approved, interventions and denied. Reviewed by Contractor daily (abnormalities to be reported to the State). Monthly Report delivered.	Monthly	Data Analytics Manager
30	Top 500 Controlled Substance Prescriber "Report Card".	Top 500 prescribers by claims, enrollees, enrollee demographic, MCO	semi-annual	Operations Director
31	Benefit limit report	Summarizing the number of recipients and claims encountering prescription limits, number of recipients and claims filled from Auto-Exemption list and number of recipients and claims filled through the Attestation process	Monthly	Data Analytics Manager
32	Top pharmacies utilizing the Attestation process	Claims adjudicated due to Attestation process	semi-annual	Operations Director
33	Effectiveness evaluation of PDL and Prior Authorization	Recommendations for changes to TennCare PDL drugs, the criteria for review and approval of drugs, and protocols and procedures	Quarterly	Clinical Director
34	Supplemental Rebate Negotiations Status	Negotiations underway and/or completed, the status of negotiation outcomes and the product-specific financial impact of the supplemental rebates on the TennCare PDL	Monthly	Clinical Director
35	Provider Educator	Demonstrating the nature and extent of educational interventions to outlier prescribers and pharmacists and the clinical and financial outcomes of those interventions.	Quarterly	Clinical Director
36	Ingredient Cost/Prescription Report	Identify claims with total cost exceeding Two Thousand Dollars (\$2,000.00). Also identify incorrect claims submission.	Monthly	Operations Director
37	Returned Mail	report the number of pieces of returned mail and reason returned, action taken	Monthly	Data Analytics Manager
38	TennCare POS Downtime/System Availability	Scheduled maintenance and unscheduled downtime of the POS database	Monthly	Data Analytics Manager

	TennCare Report Name	Specific Content	Frequency	Distribution
39	70 Reject Denial	All claims denied for "NDC Not Covered", reason for denial. ensuring that drugs set to pay are not rejecting for non-coverage.	Weekly	Operations Director
40	Legislative Control Substance Report	Top 5 claims by amount, reimbursements, by county	Annual	Chief Pharmacy Director

Attachment E

CoverRx Management Reporting Requirements

	Cover Rx Report Name	Specific Content	Frequency	Distribution
1	Enrollment Report	Update of total membership count	Monthly	CoverRx Director
2	Application Statistics	Update of application information: New Enrollment, Re-Enrollment, total applications	Monthly	CoverRx Director
3	CoverRx POS Downtime/System Availability	Scheduled maintenance and unscheduled downtime of the POS database	Monthly	CoverRx Director
4	Return Mail	Names and addresses of all mail returned and reason for return	Monthly	CoverRx Director
5	Eligibility Determination	Number of new applications and re-enrollment applications processed, denied, and rejected; and percent processed within a 5_day window	Monthly	CoverRx Director
6	Re-Enrollment Notices	Number of re-enrollment packets sent to members during their last month of active membership	Annual	CoverRx Director

	Cover Rx Report Name	Specific Content	Frequency	Distribution
7	Dual Enrollment	Daily count of CoverRx members removed from rolls due to active coverage in TennCare	Weekly/Monthly	CoverRx Director
8	CRx Mail Order Turnaround	Track completed mail order prescriptions that must ship no greater than forty-eight (48) hours	Quarterly	CoverRx Director
9	CRx Call Center SLA	Call Center Service Level Agreement for calls, answer speed and abandoned rate	Monthly	CoverRx Director
10	Performance Metrics	Chart of average members/month; total plan cost; total Rx's; cost/Rx; home delivery utilization, etc. using stats from present quarter compared to the same quarter one year earlier	Bi-annually	CoverRx Director
11	Top 10 Indications by Plan Cost	Listing of top 10 treatment categories by Plan Cost i.e., diabetic therapy, antidepressants, diagnostics, etc. and the number of Rx's dispensed in each category compared to same quarter a year earlier.	Bi-annually	CoverRx Director

	Cover Rx Report Name	Specific Content	Frequency	Distribution
12	Spend Trend on Top 5 Drugs	Bar Graph Charts for each of the top 5 drugs showing the amount spent by Quarter over 6-8 quarters	Bi-annually	CoverRx Director
13	Top 25 Drugs by Plan Cost	Top 25 drugs by quarter compared to same quarter for previous year	Bi-annually	CoverRx Director
14	Application/ Enrollment Statistics	Monthly summary of enrollment information year to date of the Clinical Advisory committee Meeting: # new enrollment apps; re-enrollment apps; denials; rejections; total apps; calls received; calls answered; average speed of answer	Bi-annually	CoverRx Director
15	Top 25 Generic and Brand Discount List Drugs	Top 25 Generic and Brand drugs on the discount list by quarter compared to same quarter previous year	Bi-annually	CoverRx Director
16	Enrollment and Drug Spend	Table of monthly membership , claims and cost per Rx year to date of the Clinical Advisory Committee Meeting compared to previous year; Data also displayed in graph format	Bi-annually	CoverRx Director
17	Mail Order Metrics	Bar graphs of mail order Rx's, reject, and denial rates by month. Pie Charts detailing Reject and Denial Edit Codes	Bi-annually	CoverRx Director
18	Retail Pharmacy Metrics	Bar graphs of mail order Rx's, reject, and denial rates by month. Pie Charts detailing Reject and Denial Edit Codes	Bi-annually	CoverRx Director

Attachment F

CoverKids Management Reporting Requirements

	CoverKids Report Name	Specific Content	Frequency	Distribution
1	Polypharmacy Case_CoverKids_Rolling12_month period	Polypharmacy Claim on a Rolling 12 month period	Quarterly	CoverKids Director
2	Therapeutic Generic Substitution and GDR Annual Report	Therapeutic Substitution & Generic Dispensing with GDR Annual Report	Annual	CoverKids Director
3	Pharmacy Network Adequacy State RX	Pharmacy Network Adequacy State CoverKids RX	Quarterly	CoverKids Director
4	Executive Summary			
5	Overview	Overview of Executive Summary	Quarterly	CoverKids Director
6	Claims By Incurred Period	Claims Incurred during the previous quarter	Quarterly	CoverKids Director
7	Top Line Performance Metrics	Plan cost PMPM, trend over previous period per quarter with percent change, and Generic Dispensing Rate (GDR)	Quarterly	CoverKids Director
8	Specialty Details	Plan Cost PMPM, trend comparison of specialty to Non-Specialty drugs	Quarterly	CoverKids Director

	CoverKids Report Name	Specific Content	Frequency	Distribution
9	Clinical Savings and Impact	Savings by offering clinically appropriate decision while decreasing Plan Cost PMPM	Quarterly	CoverKids Director
10	Top 10 Indications	Rank Indications by Plan Cost Compared with previous year same quarter	Quarterly	CoverKids Director
11	Top 10 Specialty Indications	Rank Specialty Indications by Plan Cost Compared with previous year same quarter	Quarterly	CoverKids Director
12	Upcoming Patent Expirations	Top Drugs Scheduled to lose Patent Protection within a five (5) year span, by drug name, release year, Plan Cost rank, and PMPM	Quarterly	CoverKids Director

TennCare PBM Program Performance Metrics

Table 1. TennCare Program		
	Program Area	Performance Metric
1.	PA Processing: Complete PAs	Ninety-nine point five percent (99.5%) of all complete PA requests received [phone, fax or email] shall be approved or denied with applicable reasons, within twenty four (24) hours of receipt
2.	PA Processing: Pended PAs	Missing information for Pended PAs shall be obtained by the Contractor and ninety-nine point five percent (99.5%) of all Pended PA Requests shall be approved or denied with applicable reasons, within seventy-two (72) hours of the time they were originally pended
3.	PA Processing: PAs Needing Attestation	Contractor shall provide determination of requested attestations one hundred percent (100%) of the time. Ninety-nine point five percent (99.5%) of attestations with complete information shall be approved or denied with applicable reasons, within ninety-six (96) hours of the time at which it was determined an attestation was needed.
4.	Call Center: Call Response Time	Call response time per day shall be less than thirty (<30) seconds on at least twenty-seven (27) days per month
5.	Call Center: Dropped Calls	Calls abandoned (dropped calls) after thirty (30) seconds may not exceed two percent (2%) on more than three (3) days per month.
6.	Reporting: Required Reports	No more than two (2) of the required reports referenced in Attachment D are incomplete and/or untimely in a single month
7.	Reporting: Contractor Data Warehouse	Data warehouse information shall be accessible via the reporting tool provided by Contractor and shall contain all of the data elements required in the Scope of Work, without any data output failures, such as but not limited to, inappropriate duplication or unreported index changes to the data warehouse
8.	Reporting: Ad hoc/ORR Reports	Ad hoc and ORR Reports requested by the State, including those requested from the Contractor's data analyst, shall be complete, accurate, and submitted to the State within the time frame set forth in the State's request.
9.	Adjudication System: System Errors	No inaccuracies in claims analysis, including but not limited to those listed below: <ul style="list-style-type: none"> a. One hundred percent (100%) of all drugs requiring PA to deny without PA on file; b. One hundred percent (100%) of all claims to be paid with NPI's from prescribers with prescriptive authority; c. One hundred percent (100%) of all patients that have been communicated to the Contractor for Lock-In or PA Status to be locked in and require PA for all controlled substances; d. One hundred percent (100%) of all claims with NDCs that have package quantities including decimals, to be paid only in multiples of the decimal; e. No overrides to be given by Contractor over the fill limit; f. One hundred percent (100%) of non-preferred products to deny at the point of service without PA on file; g. One hundred percent (100%) of newly marketed products to pay only with edits established by the State; and

Table 1. TennCare Program		
	Program Area	Performance Metric
		h. One hundred percent (100%) of claims covered by TennCare shall not be denied using NCPDP denial code "70 - NDC Not Covered".
10.	Adjudication System: Hours of Operation	No scheduled maintenance of the system shall be performed during Peak Times and the system shall be operational ninety-nine point ninety-nine percent (99.99%) of the time each month, except during an emergency. Failure to operate the system during an emergency shall only be excused if Contractor properly notifies TennCare of the emergency as required in the Contract.
11.	Pharmacy Network: Provider Agreements	The Contractor shall be responsible for oversight and enforcement of its Provider Agreements, including instituting corrective measures when compliance issues are found.
12.	Pharmacy Network: Provider Enrollment	All Providers shall obtain a Tennessee Medicaid provider number prior to being enrolled in the Provider Network by the Contractor, and shall continue to meet all TennCare Provider registration requirements during the entire time that they provide services to the TennCare PBM Programs pursuant to this Contract.
13.	Pharmacy Network: Pharmacy Panel Assignment	Providers shall be assigned to their appropriate pharmacy panel (Pharmacy Panel Assignment) based on TennCare-approved requirements and shall not perform services under this Contract and are outside of each Provider's panel assignment.

Table 2. CoverRx Program		
	Program Area	Performance Metric
1.	Eligibility Determination: New/Renewal Application Processing	Ninety-five percent (95%) of all new and renewal applications must be processed and a determination of eligibility made within (5) working days of receipt of a completed application.
2.	Eligibility Determination: Enrollee Letters and Communication Materials	Member Communication materials, including but not limited to, identification cards; welcoming letters about the program (including mail order contact information), Covered Drug List; and enrollment denial letters (when applicable), shall be distributed to no less than ninety-five percent (95%) of applicants within one (1) week of eligibility determination.
3.	Call Center: Call Response Time	Call response time per day shall be less than thirty (<30) seconds on at least twenty-seven (27) days per month
4.	Call Center: Dropped Calls	Calls abandoned (dropped calls) after thirty (30) seconds may not exceed two percent (2%) on more than three (3) days per month.
5.	Reporting: Required Reports	No more than two (2) of the required reports referenced in Attachment E are incomplete and/or untimely in a single month
6.	Reporting: Contractor Data Warehouse	Data warehouse information shall be accessible via the reporting tool provided by Contractor and shall contain all of the data elements required in the Scope of Work, without any data output failures, such as but not limited to, inappropriate duplication or unreported index changes to the data warehouse
7.	Reporting: Ad hoc/ORR Reports	Ad hoc and ORR Reports requested by the State, including those requested from the Contractor's data analyst, shall be complete, accurate, and submitted to the State within the time frame set forth in the State's request.

Table 3. CoverKids Program		
	Program Area	Performance Metric
1.	PA Processing: Complete PAs	Ninety-nine point five percent (99.5%) of all complete PA requests received [phone, fax or email] shall be approved or denied with applicable reasons, within twenty four (24) hours of receipt
2.	PA Processing: Pended PAs	Missing information for Pended PAs shall be obtained by the Contractor and ninety-nine point five percent (99.5%) of all Pended PA Requests shall be approved or denied with applicable reasons, within seventy-two (72) hours of the time they were originally pended
3.	Call Center: Call Response Time	Call response time per day shall be less than thirty (<30) seconds on at least twenty-seven (27) days per month
4.	Call Center: Dropped Calls	Calls abandoned (dropped calls) after thirty (30) seconds may not exceed two percent (2%) on more than three (3) days per month.
5.	Reporting: Required Reports	No more than two (2) of the required reports referenced in Attachment F are incomplete and/or untimely in a single month
6.	Reporting: Contractor Data Warehouse	Data warehouse information shall be accessible via the reporting tool provided by Contractor and shall contain all of the data elements required in the Scope of Work, without any data output failures, such as but not limited to, inappropriate duplication or unreported index changes to the data warehouse
7.	Reporting: Ad hoc/ORR Reports	Ad hoc and ORR Reports requested by the State, including those requested from the Contractor's data analyst, shall be complete, accurate, and submitted to the State within the time frame set forth in the State's request.
8.	Adjudication System: System Errors	No inaccuracies in claims analysis, including but not limited to those listed below: <ul style="list-style-type: none"> a. One hundred percent (100%) of all drugs requiring PA to deny without PA on file; b. One hundred percent (100%) of all claims to be paid with NPI's from prescribers with prescriptive authority; c. One hundred percent (100%) of all patients that have been communicated to the Contractor for Lock-In or PA Status to be locked in and require PA for all controlled substances; d. One hundred percent (100%) of all claims with NDCs that have package quantities including decimals, to be paid only in multiples of the decimal; e. No overrides to be given by Contractor over the fill limit; f. One hundred percent (100%) of non-preferred products to deny at the point of service without PA on file; g. One hundred percent (100%) of newly marketed products to pay only with edits established by the State; and h. One hundred percent (100%) of claims covered by TennCare shall not be denied using NCPDP denial code "70 - NDC Not Covered".
9.	Adjudication System: Hours of Operation	No scheduled maintenance of the system shall be performed during Peak Times and the system shall be operational ninety-nine point ninety-nine percent (99.99%) of the time each month, except during an emergency. Failure to operate the system during an emergency shall only be excused if Contractor properly notifies TennCare of the emergency as required in Section A.44.
10.	Pharmacy Network: Provider Agreements	The Contractor shall be responsible for oversight and enforcement of its Provider Agreements, including instituting corrective measures when compliance issues are found.

Table 3. CoverKids Program		
	Program Area	Performance Metric
11.	Pharmacy Network: Provider Enrollment	All Providers shall obtain a Tennessee Medicaid provider number prior to being enrolled in the Provider Network by the Contractor, and shall continue to meet all TennCare Provider registration requirements during the entire time that they provide services to the TennCare PBM Programs pursuant to this Contract.
12.	Pharmacy Network: Pharmacy Panel Assignment	Providers shall be assigned to their appropriate pharmacy panel based on TennCare-approved requirements and shall not perform services under this Contract and are outside of each Provider's panel assignment.

TennCare PBM Program Risk Sharing Module Illustration

Note: The subject matter of this Risk Sharing Module and all figures shown herein are for illustration purposes only and shall not be deemed to revise or amend any provisions of the Contract.

In this illustration, the State desires to reduce the frequency and costs associated with psychotic breaks due to failure in medication compliance used in the treatment of schizophrenia. The State and Contractor will work together to develop a Risk Sharing Module plan to achieve this goal as follows:

1. The State and Contractor will develop a methodology of identifying which enrollees are at risk for medication non-compliance. For example, the Contractor might flag in its system TennCare enrollees who fill their prescriptions late, indicating a pattern of medication noncompliance.
2. The Contractor will conduct education or care coordination efforts that will support the appropriate usage and pharmacologic treatment for the member. For example, when the Contractor receives a PA request for an oral agent to treat a flagged TennCare enrollee for schizophrenia, the Contractor may consider calling the prescribing physician and discussing the risky behavior observed and the advantages of switching to a long acting injectable to treat the TennCare enrollee for schizophrenia. This type of call between the pharmacist and the prescribing physician is known as an Academic Detailing Call (ADC). During the calls, the Contractor will be expected to provide ideas that may include, but are not limited to, interventions such as ADCs to support better clinical and pharmacologic treatment options or improve prescribing and adherence patterns.
3. Payment measures will be specified, such as, for purposes of this illustration: (i) reduction in medical, pharmacy, and/or MCO spending as reported by DRG or ICD 10 codes, (ii) quality metrics, or (iii) combinations of measures may be used as determined by the State after consultation with the Contractor.

For example, in this illustration, the State and Contractor agree to measure the impact of increased compliance with antipsychotic medications on improved health outcomes of members with schizophrenia through the reduction of inpatient psychiatric treatment facilities utilization. The State can determine the total cost difference between baseline and performance year according to the following:

- a. Identify appropriate ICD-9/ICD-10 codes for schizophrenia;
 - b. Define exclusion criteria (e.g. excluding members with < 4 months enrollment);
 - c. Determine cost of all claims for where schizophrenia is the primary or secondary diagnosis during baseline year and performance year for eligible members;
 - d. Determine total number of member months for baseline and performance year and normalize spend to account for total member months;
 - e. Determine spend categories based on service category (e.g. TennCare Claim Type Codes);
 - f. Apply average TennCare trend to baseline cost of inpatient utilization; and
 - g. Determine total savings or cost between performance year and baseline year
4. Performance quality metrics and informational quality metrics may be developed at the discretion of the State as part of the methodology for measuring clinical outcomes. In this schizophrenia Risk Sharing Module illustration, metrics such as Proportion of Days Covered (PDC), ER utilization, or inpatient psychiatric facility days may be measured. The focus will be

on developing and reporting metrics that serve as leading indicators that the parties can use to see if the goal of reducing total spending for the condition is being achieved, without having to wait for the end of the measurement period, which may be as long as a year in length. These quality metrics will be developed by the State after consultation with the Contractor. Quality metrics can be tracked for informational purposes only, or at the option of the State, Gain/Loss payments might be made based on the Contractor meeting quality metrics.

For example, prior to beginning this Risk Sharing Module illustration, if the historical baseline PDC rate was eighty percent (80%). The State may choose to determine that the goal performance quality metric is ninety percent (90%) PDC. If the Contractor's efforts increase the PDC to ninety percent (90%) by the end of the measurement period, the State can agree to pay the Contractor a predetermined amount for increasing the compliance rate, even though the ultimate measure of total spending for the condition increased over the period. In such a case, the Contractor would still owe the State money under the Gain/Loss provisions as illustrated in the Risk Sharing Module Final Gain/Loss Amount Calculations Table shown on page 3 of this Attachment H, but the amount of money owed the State would be reduced in part by the monies earned for the increased performance based on the PDC metric. Any payments would be adjusted in the final calculation to ensure that the risk corridor chosen by the Contractor is not exceeded. Data needed to track the quality metrics will be furnished as needed by the parties. For example, the Contractor may supply the PDC data, while the State would supply the medical cost of treatment data around inpatient and other treatments. Quality metrics will be tracked on quality reports developed by the parties and provided in timely reports. The Control Directive implementing a particular Risk Sharing Module would contain the specifics of the overall goal, the quality metrics, the reporting requirements and the quality reports.

5. In this illustration, the change in MCO spending will be measured according to the parameters set forth in the Control Directive implementing the Risk Sharing Module, with quality payments, if applicable, factored into the calculation as specified in the Control Directive. Gains or Losses would be split equally between the State and the Contractor. The Gain/Loss amount will be assessed as a percentage of the total annual TennCare PBM Program Administrative Fee specified in the Contract, up to the limit of the risk percentage chosen by the Contractor in the RFP Cost Proposal for this Contract.
6. In this illustration, in order to calculate the Risk Sharing Module Final Gain/Loss Amount in the five (5) scenarios shown on page 3 of this Attachment H, the following calculation is used:

$$\begin{array}{r}
 \text{Performance Year Spend} \\
 - \text{Baseline Year Spend} \\
 \hline
 = \text{Total Risk Sharing Gain/Loss Amount} \\
 + \text{Applicable Performance Quality Metric Payment} \\
 \hline
 = \text{Final Gain/Loss Amount}
 \end{array}$$

**TennCare PBM Program Risk Sharing Module Illustration
Final Gain/Loss Amount Calculations Table
(All numbers below are for illustrative purposes only)**

<p><i>This illustration is based on the following assumptions:</i> The Contractor chooses to place six percent (6%) of the total annual TennCare PBM Program Administrative Fee at risk. If the Contractor's total annual TennCare PBM Program Administration Fee is \$25 million, the maximum Gain/Loss for the Contractor would be $\pm \\$1.5$ million ($\\$25M \times 0.06\% = \\$1.5M$)</p>			
Scenario	Total Gain/Loss (Performance year spend minus trended baseline year spend)	Performance Quality Metric Payment (90% Threshold)	Final Gain/Loss Amount
A.	$\begin{array}{r} \$33.9 \text{ million (performance year)} \\ - \$35.0 \text{ million (baseline year)} \\ \hline (\$1.1 \text{ million savings}) \end{array}$	$\begin{array}{r} + \$200,000 \\ \text{(PDC increases to 90\%)} \end{array}$	\$1.3 Million paid to Contractor
B.	$\begin{array}{r} \$30.0 \text{ million (performance year)} \\ - \$35.0 \text{ million (baseline year)} \\ \hline (\$5.0 \text{ million savings}) \end{array}$	$\begin{array}{r} + \$200,000 \\ \text{(PDC increases to 90\%)} \end{array}$	\$1.5 Million paid to Contractor (max payment amount)
C.	$\begin{array}{r} \$36.0 \text{ million (performance year)} \\ - \$35.0 \text{ million (baseline year)} \\ \hline \$1.0 \text{ million loss} \end{array}$	$\begin{array}{r} + \$200,000 \\ \text{(PDC increases to 90\%)} \end{array}$	\$800,000 paid to State
D.	$\begin{array}{r} \$38.0 \text{ million (performance year)} \\ - \$35.0 \text{ million (baseline year)} \\ \hline \$3.0 \text{ million loss} \end{array}$	$\begin{array}{r} + \$200,000 \\ \text{(PDC increases to 90\%)} \end{array}$	\$1.3 Million paid to State
E.	$\begin{array}{r} \$40.0 \text{ million (performance year)} \\ - \$35.0 \text{ million (baseline year)} \\ \hline \$5.0 \text{ million loss} \end{array}$	$\begin{array}{r} \$0 \\ \text{(PDC increases to 82\%)} \end{array}$	\$1.5 Million paid to State (max payment amount)

**SAMPLE ADMINISTRATIVE AND ESCROW AGREEMENT
REGARDING WITHHOLD AND ESCROW OF PART OF CONTRACTOR'S
TennCare ADMINISTRATIVE FEES PENDING
CMS CERTIFICATION OF CONTRACTOR'S TennCare PBM SYSTEM**

This Administrative and Escrow Agreement ("Administrative/Escrow Agreement") by and between the State of Tennessee, Department of Finance and Administration, Division of TennCare ("State" or "TennCare") and _____ ("Contractor" or "_____") is made effective as of this ___ day of ____, 20__ ("Effective Date"), and concerns the following matters:

WHEREAS, State and Contractor entered into that certain contract, identified as State Contract # _____ dated _____, 2019 ("Contract"), whereby Contractor agreed to provide pharmacy benefit management ("PBM") services pursuant to the requirements and provisions set forth in the Contract for the TennCare, CoverRx and CoverKids PBM Programs operated by the State. All capitalized terms not otherwise defined herein shall have the meaning assigned to them in the Contract; and

WHEREAS, Contract Section A.40.b. requires the PBM system that Contractor is required to develop and operate for the TennCare PBM Program ("TennCare PBM System") to be certified by the Centers for Medicare and Medicaid Services ("CMS Certification") so the State can qualify for enhanced federal financial participation ("EFFP") for the TennCare PBM Program; and

WHEREAS, beginning on the date the Contractor assumes full responsibility for the TennCare PBM Program ("TennCare PBM Go Live"), the State will begin to pay a monthly TennCare Administrative Fee ("TennCare Admin Fee") to the Contractor for its services pursuant to Contract Section C.3.2(2); and

WHEREAS, beginning on December 1, 2019, the State is permitted to withhold specified portion(s) of Contractor's TennCare Admin Fee each month as set forth in Contract Section A.40.b pending CMS Certification; and

WHEREAS, the State has determined that it is in the best interests of the TennCare PBM Program to pay the TennCare Admin Fees withheld by the State pursuant to Contract Section A.40.b. and this Administrative/Escrow Agreement (collectively, the "Escrowed TennCare Admin Fees"), into escrow, to be governed pursuant to this Administrative/Escrow Agreement, pending distribution of the Escrowed TennCare Admin Fees pursuant to the terms and requirements set forth in the Administrative/Escrow Agreement; and

WHEREAS, the Escrowed TennCare Admin Fees shall be held by the State pending timely and satisfactory completion of the requirements contained herein and in Contract Section A.40.b. Upon receiving written confirmation from CMS that it has either: (i) granted CMS Certification to the TennCare PBM System, or (ii) determined that it will not grant CMS Certification to the TennCare PBM System, the State shall distribute the Escrowed TennCare Admin Fees to the Contractor and/or the State, pursuant to the terms of Contract Section A.40.b and this Administrative/Escrow Agreement; and

WHEREAS, State and Contractor now desire to enter into this Administrative/Escrow Agreement, the terms of which shall govern the State's escrow of the Escrowed TennCare Admin Fees and distribution of such funds.

NOW, THEREFORE, in consideration of the foregoing facts and circumstances, the mutual covenants and promises contained herein and other good and valuable consideration, the receipt and legal sufficiency of which are hereby acknowledged by each of the parties, State and Contractor hereby agree to the following:

Section 1. Mutual Agreement by Parties

The State and Contractor agree to be bound as follows:

- 1.1 Withhold Upon Timely Submission to TennCare of TennCare PBM System Artifacts and Documentation. Beginning December 1, 2019 the State shall withhold seven and one half percent (7.5%) of the Contractor's monthly TennCare Admin Fee each month or part of a month until the TennCare PBM System has been successfully certified by CMS. Provided the Contractor made timely submission to TennCare of all TennCare PBM System artifacts and documentation required in Contract Section A.40.b.1 to allow TennCare to submit

its initial system certification request to CMS by January 3, 2020, upon receipt of written notice from CMS that the TennCare PBM System is successfully certified, TennCare shall return all TennCare Admin Fee withhold amounts held pursuant to Contract Section A.40.b.1 and this Section 1.1 to the Contractor as set forth below.

- 1.2. Permanent Withhold for Failure to Make Timely Submission of TennCare PBM System Artifacts and Documentation to TennCare. If the Contractor fails to provide the necessary TennCare PBM System artifacts and documentation by December 1, 2019, as permitted in Contract Section A.40.b.2 and this Administrative/Escrow Agreement, the State shall permanently withhold seven and one half percent (7.5%) of the Contractor's monthly TennCare Admin Fee beginning on December 1, 2019, and continuing each month or part of a month until the necessary TennCare PBM System artifacts and documentation have been provided. The State shall keep any such permanent monthly withholds that occur during the period of time beginning December 1, 2019 and continuing each month or part of a month until the necessary artifacts and documentation have been provided as provided in Contract Section A.40.b.2.. Such permanently withheld funds shall be deemed full and complete compensation to the State for delays caused by Contractor in submitting TennCare's initial system certification request to CMS.
- 1.3. Increased Withhold Due to CMS Corrective Action Notice(s). Following TennCare's initial system certification request to CMS, if CMS identifies and requests corrective action as a result of its review of the TennCare PBM System, the Contractor shall have sixty (60) calendar days from the date CMS provides the written corrective action notice to the State to perform all requirements of the corrective action and provide any required artifacts and/or documentation to TennCare as set forth in Contract Section A.40.b.3. TennCare shall provide Contractor with a copy of CMS' written corrective action notice within three (3) business days of receiving it. Upon receipt from the Contractor of the required evidence that the Contractor has complied with CMS' corrective action request, TennCare shall resubmit its system certification request to CMS with the evidence that the corrective actions in connection with the TennCare PBM System have been successfully completed by Contractor. Upon review of the State's resubmitted systems certification request, if CMS determines there are additional corrective actions needed in order to certify the TennCare PBM System, the State shall notify Contractor upon receipt of CMS' supplemental corrective action request, and this process shall be repeated, as needed, until the TennCare PBM System is certified by CMS.
- 1.4. If the Contractor fails to provide the necessary artifacts and documentation, or fails to begin or complete the corrective action(s) by the sixtieth (60th) day from the date the initial corrective action was requested by CMS, the State shall, on the sixty-first (61st) day from the date the initial corrective action was requested by CMS, increase the monthly withhold from seven and one half percent (7.5%) of the Contractor's monthly Administrative Fee related to the TennCare PBM Program to twelve and one half percent (12.5%), as a permanent withhold pursuant to Contract Section A.40.b.3. Such twelve and one half percent (12.5%) permanent withhold shall continue each month or part of a month until CMS notifies the State in writing that the corrective action(s) relating to the TennCare PBM System have been successfully mitigated. At that time, if CMS does not simultaneously confirm that the Contractor's corrective actions have been accepted and provide written confirmation that the TennCare PBM System is certified to receive EFFP, the monthly withhold shall decrease to seven and one half percent (7.5%) of the Contractor's monthly Administrative Fee related to the TennCare PBM Program, to be withheld each month or part of a month until the State receives written confirmation from CMS that the TennCare PBM System has been certified.
- 1.5. Upon receiving CMS certification and pursuant to Contract Section A.40.b.3, the State shall keep the full amount of any twelve and one half percent (12.5%) permanent monthly withhold that occurs during the period of time identified above beginning with the sixty-first (61st) day following the date the initial corrective action was requested by CMS and ending on the date the State receives written confirmation from CMS that the Contractor's corrective action(s) have been accepted by CMS. Such twelve and one half percent (12.5%) permanent monthly withhold funds shall be deemed by the State to be full and complete compensation to the State for delays caused by Contractor in obtaining certification for the TennCare PBM System, and shall be in addition to any permanent seven and one half percent (7.5%) withholds kept by the State pursuant to this Administrative/Escrow Agreement. If, during the period of time beginning with the date the State receives written confirmation that CMS has accepted all of the Contractor's corrective actions and ending on the date the State receives written confirmation from CMS that the TennCare PBM System is certified, the State made any seven and one half percent (7.5%) withholds from the Contractor's TennCare Admin Fees, these withholds shall be paid to the Contractor pursuant to Contract Section A.40.b.3 and the terms hereof.

- 1.6. The State may simultaneously withhold funds from Contractor's TennCare Admin Fee pursuant to this Administrative/Escrow Agreement and Contract Sections A.40.b.1 through A.40.b.3. When TennCare receives written confirmation from CMS that certification of the TennCare PBM System has been achieved, the State shall provide a copy of the written certification notice to the Contractor within five (5) business days of receipt from CMS, and release any TennCare Admin Fees held pursuant to Contract Sections A.40.b.1 through A.40.b.3 and the terms set forth herein, that have not been forfeited to the State, with such funds to be included in the next monthly TennCare Admin Fee payable to Contractor.
- 1.7. If CMS does not certify the TennCare PBM System prior to the end of the Contract, but the State, in its sole discretion, determines that the Contractor satisfied all program and technical requirements required for EFP, the State shall release to Contractor all remaining funds withheld from Contractor's TennCare Admin Fees that were not permanently forfeited to the State pursuant to this Administrative/Escrow Agreement and Contract Sections A.40.b.2 and A.40.b.3. If released, such funds will be included in the next monthly TennCare Admin Fee payable to Contractor.
- 1.8. In the event Contractor fails to meet the requirements of Contract Sections A.40.b.2 and A.40.b.3 as set forth in Section 1 above, the Contractor shall irrevocably forfeit any right, title or claim to the applicable portion of the Escrowed TennCare Admin Fees related to that requirement.

Section 2. Escrow Agreement.

- 2.1. Escrowed Funds. Contractor has agreed to the withholding arrangement relating to CMS Certification of the TennCare PBM System set forth in the Contract and herein whereby the State shall deposit into escrow with the State the Escrowed TennCare Admin Fees pursuant to Contract Section A.40.b and Section 1 of this Administrative/Escrow Agreement to be held, administered and distributed to the appropriate party pursuant to the terms of this Administrative/Escrow Agreement. The term "Escrowed Amount" when used herein shall be deemed to refer to the total amount of monies so escrowed, or any portion thereof.
- 2.2. Contingent Revenue Account. State shall hold the Escrowed Funds in a separately maintained account ("Account") to be designated within the State's Chart of Accounts until the escrow is terminated according to the terms of this Administrative/Escrow Agreement.
- 2.3. Payment of Escrowed Funds Pursuant to Contract Section A.40.b and Section 1 of this Administrative/Escrow Agreement, Final Accounting, Distribution of Escrowed Funds and Forfeited Escrowed Funds; and Termination of Escrow.
 - 2.3.a. Final Accounting. Within ten (10) business days of the State's receipt of final written notice from CMS that it has either: (i) granted CMS Certification to the TennCare PBM System, or (ii) determined that it will not grant CMS Certification to the TennCare PBM System, the State shall provide Contractor with a written Final Accounting and Distribution of Escrowed Funds ("Final Accounting") showing all Escrowed TennCare Admin Fees previously paid into escrow by the State, the amount of any Escrowed TennCare Admin Fees previously paid to the Contractor, the amount of any Escrowed TennCare Admin Fees previously irrevocably forfeited to the State by Contractor ("Forfeited Escrow Funds"), the balance of Escrowed TennCare Admin Fees held by the State, and the proposed amounts payable to the Contractor and the State, if any, pursuant to the provisions of Contract Section A.40.b and this Administrative/Escrow Agreement. The State shall use the Final Accounting to distribute and pay ("Distribution") the indicated Escrowed TennCare Admin Fees and/or Forfeited Escrowed Funds to the appropriate parties.
 - 2.3.b. Termination of Escrow. The Account established pursuant to this Administrative/Escrow Agreement shall be terminated upon the State making Distribution of any remaining Escrowed TennCare Admin Fees owed to the Contractor, and any Forfeited Escrowed Funds owed to the State pursuant to the Final Accounting.

Section 3. Miscellaneous.

- 3.1. Incorporation of Contract and Administrative/Escrow Agreement. The parties agree that the terms and conditions of the Contract are incorporated herein and shall be considered to be part of this Administrative/Escrow Agreement. The terms of the Contract that are unaltered by this Administrative/Escrow Agreement shall remain in full force and effect against each party.

- 3.2. Voluntary Agreement. The parties represent that they have read and understand all the terms of this Administrative/Escrow Agreement, and, on the advice of counsel, they have freely and voluntarily, without duress, and with full knowledge of its legal significance, entered into this Administrative/Escrow Agreement. Such representations shall survive to the execution of this Administrative/Escrow Agreement indefinitely.
- 3.3. Authority of Parties. As a condition precedent to any obligations or liabilities of the parties, Contractor expressly represents to State, and State expressly represents to Contractor, that: (i) they have full capacity and authority to enter into this Administrative/Escrow Agreement, and (ii) they know of no other person or entity that intends to assert a claim by, through, under or on their behalf. This representation survives the execution of this Administrative/Escrow Agreement indefinitely.
- 3.4. Time of Essence. Time is of the essence of this Administrative/Escrow Agreement and each and every term and provision hereof.
- 3.5. Modification. A modification of any provision herein contained, or any other amendment to this Administrative/Escrow Agreement, shall be effective only if the modification or amendment is in writing and signed by both State and the Contractor.
- 3.6. Waiver. No waiver by any party hereto of any breach or default shall be considered to be a waiver of other breach or default. The waiver of any condition shall not constitute a waiver of any other breach or default with respect to any covenant, representation or warranty.
- 3.7. Number and Gender. As used in this Administrative/Escrow Agreement, each of the masculine, feminine, and neuter includes the other, singular includes the plural and plural includes the singular.
- 3.8. Governing Law. This Administrative/Escrow Agreement shall be governed by, interpreted under and construed and enforced in accordance with the laws of State of Tennessee.
- 3.9. Construction. Headings at the beginning of each Section and subsection are solely for the convenience of the parties and are not a part of this Administrative/Escrow Agreement. Unless otherwise indicated, all references herein to Sections, subsections, paragraphs, subparagraphs or provisions are to those in this Administrative/Escrow Agreement. Any reference to a paragraph or Section herein includes all subparagraphs or subsections thereof. This Administrative/Escrow Agreement shall not be construed as if it had been prepared by only State or Contractor, but rather as if both State and Contractor had prepared the same. In the event any portion of this Administrative/Escrow Agreement shall be declared by any court of competent jurisdiction to be invalid, illegal or unenforceable, such portion shall be deemed severed from this Administrative/Escrow Agreement, and the remaining parts hereof shall remain in full force and effect, as fully as though such invalid, illegal or unenforceable portion had never been part of this Administrative Agreement.
- 3.10. Integration of Other Assignments. This Administrative/Escrow Agreement, the Contract, and any document integrated into the Contract pursuant to the Contract's terms, set forth the entire agreement and understanding of the parties with respect to the matters set forth herein and supersedes all previous written or oral understandings, dealings, agreements, contracts, correspondence and documentation with respect thereto. Any oral representations or modifications concerning this Administrative/Escrow Agreement shall be of no force or effect.
- 3.11. Non-Waiver of Rights. No failure or delay of either party in the exercise of any right given to such party hereunder shall constitute a waiver thereof unless the time specified herein for exercise of such right has expired, nor shall any single or partial exercise of any right preclude other or further exercise thereof or of another right.
- 3.12. Taxes. State and Contractor further acknowledge and agree that Contractor has sole responsibility for payment of any and all taxes that may be assessed against it arising from or relating to this Administrative/Escrow Agreement and the payments made to the Contractor thereunder.
- 3.13. No-Third Party Beneficiaries. No person or entity shall be deemed to be a third party beneficiary hereof, and nothing in this Administrative/Escrow Agreement, either expressed or implied, is intended to confer upon any person or entity, other than State or Contractor (and their respective nominees, successors, and

assigns), any rights remedies, obligations or liabilities under or by reason of this Administrative/Escrow Agreement.

- 3.14. Successors and Assigns. This Administrative/Escrow Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors and assigns and is enforceable against them in accordance with its terms. Notwithstanding the foregoing, Contractor may not assign any of its rights or obligations hereunder without the prior written consent of State.
- 3.15. Counterparts. The Administrative/Escrow Agreement may be executed in several counterparts, each of which shall be deemed an original and all which shall be deemed one and the same instrument.

[signature page to follow]

IN WITNESS WHEREOF, the parties hereto caused this Administrative/Escrow Agreement to be executed as of the Effective Date.

STATE OF TENNESSEE
Department of Finance and Administration
Division of TennCare

(Contractor)

By: _____

By: _____

Name: _____

Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

BIDDER'S LIBRARY

- (1) **MEDICAID ENTERPRISE CERTIFICATION TOOLKIT (MECT) 2.2
Modular Required Artifacts List**

<https://www.tn.gov/content/dam/tn/tenncare/documents2/1MEDICAIDENTERPRISECERTIFICATIONTOOLKIT.pdf>

- (2) **SAMPLE REPORT TEMPLATES**

TennCare Reports

<https://www.tn.gov/content/dam/tn/tenncare/documents2/2aSAMPLEREPORTTEMPLATESTennCare.zip>

CoverRx Reports

<https://www.tn.gov/content/dam/tn/tenncare/documents2/2bSAMPLEREPORTTEMPLATESCoverRx.zip>

CoverKids Reports

<https://www.tn.gov/content/dam/tn/tenncare/documents2/2cSAMPLEREPORTTEMPLATESCoverKids.zip>

- (3) **Claim Extract Layouts**

<https://www.tn.gov/content/dam/tn/tenncare/documents2/3ClaimExtractLayouts.xls>

- (4) **834 Supplemental Documents**

<https://www.tn.gov/content/dam/tn/tenncare/documents2/4834SupplementalDocuments.pdf>

- (5) **TennCare Member Identification Card-General Requirements**

<https://www.tn.gov/content/dam/tn/tenncare/documents2/5TennCareMemberIdentificationCardGeneralRequirements.docx>

- (6) **Notices**

<https://www.tn.gov/content/dam/tn/tenncare/documents2/6Notices.zip>

- (7) **Pharmacy Network**

<https://www.tn.gov/content/dam/tn/tenncare/documents2/7PharmacyNetwork.xlsx>

- (8) **Drug List and Drug Criteria**

PDL:

<https://www.tn.gov/content/dam/tn/tenncare/documents2/8aPDLTennCarePDL.PDF>

<https://www.tn.gov/content/dam/tn/tenncare/documents2/8aPDLTennCareFormulary.zip>

Prior authorization Criteria & quantity limits:

<https://www.tn.gov/content/dam/tn/tenncare/documents2/8bPriorauthorizationCriteriaquantitylimits.pdf>

Additional criteria for agents not listed on the PDL that links from the main page:

<https://www.tn.gov/content/dam/tn/tenncare/documents2/8cAdditionalcriteriaforagentsnotlistedonthepDLthatlinksfrom.mht>

Auto-exempt list & attestation list are:

<https://www.tn.gov/content/dam/tn/tenncare/documents2/8dTennCareAutoExemptList1.pdf>

https://www.tn.gov/content/dam/tn/tenncare/documents2/8dTennCareAutoExempt_List2.pdf

Morphine daily equivalents calculations: see CMS reference chart here, please note only products in the short-acting narcotic and long-acting narcotic PDL classes will be subject to the edit:

<https://www.tn.gov/content/dam/tn/tenncare/documents2/8eMorphinedailyequivalentscalculations.pdf>

Overrides, ICD overrides:

<https://www.tn.gov/content/dam/tn/tenncare/documents2/8fOverridesICDoverrides.pdf>

(9) MECT 2.2 Checklists

<https://www.tn.gov/content/dam/tn/tenncare/documents2/9aMECT22Checklists.zip>

Access and Delivery Checklist
Information Architecture Checklist
Integration and Utility Checklist
Intermediary and Interface Checklist
Pharmacy Checklist (MMIS) Module
Standards and Conditions Checklist

(10) TennCare AE – SSP Template, MARS – E 2.0

<https://www.tn.gov/content/dam/tn/tenncare/documents2/10TennCareAESSPTemplateMARSE2.pdf>

(11) Magellan Health Services TennCare Portal Files

<https://www.tn.gov/content/dam/tn/tenncare/documents2/MagellanHealthServicesTennCarePortalfiles.zip>

HIPAA Business Associate Agreement

THIS HIPAA BUSINESS ASSOCIATE AGREEMENT (“Agreement”) is between The State of Tennessee, Division of TennCare (“TennCare” or “Covered Entity”), located at 310 Great Circle Road, Nashville, TN 37243 and _____

_____ (“Business Associate”), located at _____, 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

The Parties acknowledge that they are subject to the Privacy and Security Rules (45 C.F.R. 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, and as amended by the final rule modifying the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act (HITECH). 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:

In the course of performing services under a Service Agreement, Business Associate may come into contact with, use, or disclose Protected Health Information (“PHI”). 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 rules and 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 that Business Associate may receive (if any) from or on behalf of Covered Entity, and, therefore, execute this Agreement.

1. DEFINITIONS

All capitalized terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms defined in 45 C.F.R. Parts 160 through 164 or other applicable law or regulation. A reference in this Agreement to a section in the Privacy or Security Rule means the section as in effect or as amended.

1.1 “Commercial Use” means obtaining PHI 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.

1.2 “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 Business Associate’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.

1.3 "Electronic Signature" means an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

1.4 "Marketing" shall have the meaning under 45 C.F.R. § 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 TennCare.

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

2.1 Compliance with the Privacy Rule. Business Associate shall 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 HITECH Act Compliance. The Health Information Technology for Economic and Clinical Health Act (HITECH) was adopted as part of the American Recovery and Reinvestment Act of 2009. HITECH and its implementing regulations impose new requirements on Business Associates with respect to privacy, security, and Breach notification. Business Associate hereby acknowledges and agrees that to the extent it is functioning as a Business Associate of Covered Entity, Business Associate shall comply with any applicable provisions of HITECH. Business Associate and the Covered Entity further agree that the provisions of HIPAA and HITECH that apply to business associates and that are required to be incorporated by reference in a business associate agreement have been incorporated into this Agreement between Business Associate and Covered Entity. Should any provision not be set forth specifically, it is as if set forth in this Agreement in its entirety and is effective as of the Applicable Effective Date, and as amended.

2.3 Business Management. Business Associate may use and disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of Business Associate. Business Associate may provide data aggregation services relating to the Health Care Operations of TennCare, or as required by law. Business Associate is expressly prohibited from using or disclosing PHI other than as permitted by this Agreement, any associated Service Agreements, or as otherwise permitted or required by law, and is prohibited from uses or disclosures of PHI that would not be permitted if done by the Covered Entity.

2.4 Privacy Safeguards and Policies. Business Associate shall 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.

2.5 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 agreement with Business Associate, to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information except for the provision at section 4.6, which shall only apply to the Business Associate notwithstanding the requirements in this section 2.5.

2.6 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.

2.7 Reporting of Violations in Use and Disclosure of PHI. Business Associate shall require its employees, agents,

and Subcontractors to promptly report to Business Associate immediately upon becoming aware of 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 immediately upon becoming aware of, and in no case later than 48 hours after discovery.

2.8 Breach of Unsecured Protected Health Information. As required by the Breach Notification Rule, Business Associate shall, and shall require its Subcontractor(s) to, maintain systems to monitor and detect a Breach of Unsecured PHI, whether in paper or electronic form.

2.8.1 Business Associate shall provide to Covered Entity notice of a Breach of Unsecured PHI immediately upon becoming aware of the Breach, and in no case later than 48 hours after discovery.

2.8.2 Business Associate shall cooperate with Covered Entity in timely providing the appropriate and necessary information to Covered Entity.

2.8.3 Covered Entity shall make the final determination whether the Breach requires notification to affected individuals and whether the notification shall be made by Covered Entity or Business Associate.

2.9 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 C.F.R. § 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.

2.10 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 (in any form they choose, provided the PHI is readily producible in that format) 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 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 fifteen (15) 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 (30) day requirement of 45 C.F.R. § 164.524.
- (c) If the Party designated above as 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, or Individual's designee, 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.
- (d) Business Associate is permitted to send an Individual or Individual's designee unencrypted emails including Electronic PHI if the Individual requests it, provided the Business Associate has advised the Individual of the risk and the Individual still prefers to receive the message by unencrypted email.

2.11 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 C.F.R. § 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.

2.12 Recording of Designated Disclosures of PHI. Business Associate shall document any and all disclosures of PHI by Business Associate or its agents, including 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 C.F.R. § 164.528.

2.13 Accounting for Disclosures of PHI. The Business Associate agrees to provide to Covered Entity or to an Individual, or Individual's designee, 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 C.F.R. § 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 an 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 or Individual's designee. 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.

2.14 Minimum Necessary. Business Associate shall 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.

2.14.1 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.

2.14.2 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.

2.14.3 Business Associate shall adequately and properly maintain all PHI received from, or created or received on behalf of, Covered Entity.

2.15 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.

2.16 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.

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

3.1 Compliance with Security Rule. Business Associate shall 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 shall 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 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 except for the provision in Section 4.6.

3.4 Reporting of Security Incidents. The Business Associate shall track all Security Incidents as defined and as required by HIPAA and shall periodically report such Security Incidents in summary fashion as may be requested by the Covered Entity. 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 related Security Incident, immediately upon becoming aware 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.

3.4.1 Business Associate identifies the following key contact persons for all matters relating to this Agreement:

Business Associate shall notify Covered Entity of any change in these key contacts during the term of this Agreement in writing within ten (10) business days.

3.5 Contact for Security Incident Notice. Notification for the purposes of Sections 2.8 and 3.4 shall be in writing made by email/fax, certified mail or overnight parcel immediately upon becoming aware of the event, with supplemental notification by facsimile and/or telephone as soon as practicable, to:

TennCare Privacy Officer
310 Great Circle Rd.
Nashville Tennessee 37243
Phone: (615) 507-6855
Facsimile: (615) 734-5289
Email: Privacy.TennCare@tn.gov

3.6 Security Compliance Review upon Request. Business Associate shall 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 and Human Services or the Secretary's designee, in a time and manner designated by the requester, for purposes of determining Covered Entity's, Business Associate's compliance with the Security Rule.

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

3.8 Refraining from intimidation or retaliation. A Covered Entity or Business Associate may not threaten, intimidate, coerce, harass, discriminate against, or take any other retaliatory action against any Individual or other person for-- (a) Filing of a complaint under 45 C.F.R. § 160.306; (b) testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing; or (c) opposing any act or practice made unlawful, provided the Individual or person has a good faith belief that the practice opposed is unlawful, and the manner of opposition is reasonable and does not involve a disclosure of PHI in violation of HIPAA.

4. USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Use and Disclosure 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 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 or to carry out the legal responsibilities 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 immediately upon becoming aware.

4.4 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 (1) of this Agreement.

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

4.6 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.

4.7 Prohibition of Other Uses and Disclosures. Business Associate shall not use or disclose PHI that is Genetic Information for underwriting purposes. Moreover, the sale, marketing or the sharing for commercial use or any purpose construed by Covered Entity as the sale, 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, is prohibited.

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.

4.10 Business Associate shall enter into written agreements that are substantially similar to this Business Associate Agreements with any Subcontractor or agent which Business Associate provides access to Protected Health Information.

4.11 Business Associates shall implement and maintain information security policies that comply with the HIPAA Security Rule.

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 C.F.R. § 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 C.F.R. § 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. TERM AND TERMINATION

6.1 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 6.3.5 below shall apply.

6.2 Termination for Cause. This Agreement authorizes and Business Associate acknowledges and agrees Covered Entity shall have the right to 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.

6.2.1 Upon Covered Entity's knowledge of a 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.

6.3 Effect of Termination. Upon termination of this Agreement for any reason, except as provided in subsections 6.3.2 and 6.3.5 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.

6.3.1 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.

6.3.2 This provision (Section 6.3 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 6.3.5.

6.3.3 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.

- 6.3.4 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 6.3 and its subsections.
- 6.3.5 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.

7. MISCELLANEOUS

7.1 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.

7.2 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.

7.3 Survival. The respective rights and obligations of Business Associate under Confidentiality and Section 6.3 of this Agreement shall survive the termination or expiration of this Agreement.

7.4 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.

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

7.6 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 electronic mail, 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, and fax numbers and to promptly supplement this Agreement as necessary with corrected information.

Notifications relative to Sections 2.8 and 3.4 of this Agreement must also be reported to the Privacy Officer pursuant to Section 3.5.

COVERED ENTITY:
Wendy Long, MD, Director
Division of TennCare
310 Great Circle Rd.
Nashville, TN 37243
Fax: (615) 253-5607

BUSINESS ASSOCIATE:

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.

7.7 Transmission of PHI or Other Confidential Information. Regardless of the transmittal methods permitted above, Covered Entity and Business Associate agree that all deliverables set forth in this Agreement that are required to be in the form of data transfers shall be transmitted between Covered Entity and Business Associate via the data transfer method specified in advance by Covered Entity. This may include, but shall not be limited to, transfer through Covered Entity's SFTP system. Failure by the Business Associate to transmit such deliverables in the manner specified by Covered Entity may, at the option of the Covered Entity, result in liquidated damages if and as set forth in one (1) or more of the Service Agreements between Covered Entity and Business Associate listed above. All such deliverables shall be considered effectively submitted upon receipt or recipient confirmation as may be required.

7.8 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.

7.9 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.

7.10 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 HITECH 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).

7.11 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.

7.12 Validity of Execution. Unless otherwise agreed, the parties may conduct the execution of this Business Associate Agreement transaction by electronic means. The parties may agree that an electronic record of the Agreement containing an Electronic Signature is valid as an executed Agreement.

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

DIVISION OF TennCare

BUSINESS ASSOCIATE

By: _____
Wendy Long, MD, Director
Date: _____

By: _____
Date: _____

Division of TennCare
310 Great Circle Road
Nashville, TN 37243
Fax: (615) 253-5607

