STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION

REQUEST FOR PROPOSALS
FOR
THIRD PARTY ADMINISTRATOR SERVICES
FOR THE STATE'S PUBLIC SECTOR HEALTH PLANS

RFP # 31786-00148

RELEASE #4

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1. INTRODUCTION

The State of Tennessee, State, Local Education, and Local Government Insurance Committees, hereinafter referred to as "the State," issues this Request for Proposals (RFP) to define minimum contract requirements; solicit responses; detail response requirements; and, outline the State's process for evaluating responses and selecting a contractor to provide the needed goods or services.

Through this RFP, the State seeks to procure necessary goods or services at the most favorable, competitive prices and to give ALL qualified respondents, including those that are owned by minorities, women, service-disabled veterans, persons with disabilities and small business enterprises, an opportunity to do business with the state as contractors, subcontractors or suppliers.

1.1. Statement of Procurement Purpose

The State intends to secure two contracts with Third Party Administrators (TPAs) each with a Preferred Provider Organization (PPO) network servicing all ninety-five (95) Tennessee counties statewide as well as nationally for Members residing or traveling outside of the state. The TPAs shall provide access to an existing (current) efficient, high-quality, cost effective commercial PPO network that meets the state's access requirements. Additionally, the TPAs shall provide access to their most inclusive and broadest existing (current) commercial PPO network. The broad network option(s) shall be implemented at the State's discretion and may be implemented on a separate timeline, if at all. Network surcharges, to be paid by the Member, may also be added to the most expensive network options. Benefits Administration currently utilizes such surcharges to incentivize the use of the most cost-effective networks while also providing Member choice. The two TPAs shall offer all benefit options currently offered by the State or any other benefit options that the State subsequently develops. The State's current benefit designs may be reviewed at http://partnersforhealthtn.gov/.

The State will select the two best evaluated proposals resulting in two contracts. The TPA shall provide network administration, utilization management, claims adjudication, call center services, and benefits communication materials for Members. Contractors shall perform all services described in the Scope of Services of the pro forma contract (RFP Attachment 6.6).

Background and Context

The State is the largest purchaser of employer-based health care services in Tennessee. The State operates three financially independent self-funded public sector plans which provide health benefits to approximately 288,000 employees, retirees and dependents of the State, the University of Tennessee (UT) system, the Tennessee Board of Regents (TBR) system, Local Education Agencies (LEAs), and Local Government agencies (LGA). Approximately half (144,000) of the Members are employees and retirees while dependents make up the other half. See the most recent Annual Report for a description of program and plan information. The report is available at www.tn.gov/partnersforhealth/publications/reports.html. Current benefit options include self-funded PPOs and Consumer Driven High Deductible Plans with Health Savings Accounts (CDHP/HSAs). BlueCross BlueShield of Tennessee and CIGNA Healthcare administer the plans in all three grand divisions.

State Group Insurance Plan

The State Group Insurance Plan is governed by the State Insurance Committee and is a financially separate, self-funded program. The State plan provides medical coverage to approximately 149,000 state and higher education employees, pre-65 retirees, COBRA participants and their dependents. The State, as the employer, contributes monthly to premiums in an amount equal to approximately 80% of the premium cost of one or more of the basic health plans. Approximately $576 million in medical Claims and $240 million in pharmacy and behavioral health Claims were paid under these Plan options during Plan year 2019.

The State has a separate carve-out contract with CaremarkPCS Health for pharmacy benefits and a separate carve-out contract with Optum for the employee assistance program (EAP), mental health and substance use benefit. The employee population health program is administered by ActiveHealth Management and delivers

disease management, lifestyle management, and weight management. Supplemental Medical Insurance for Retirees with Medicare is offered to eligible retirees and is administered by UMR/POMCO

Voluntary benefits offered to State Plan Members and retirees include:

- Prepaid dental plan - Cigna
- Preferred dental organization plan - Aetna
- Vision plan – Davis Vision
- Life Insurance – Securian Financial
- Disability Insurance – MetLife
- Health Savings and Flexible Savings Accounts – Optum Banking

Local Education Group Insurance Plan

The Local Education Group Insurance Plan is governed by the Local Education Insurance Committee and is a financially separate, self-funded program for employees and retirees of 125 Local Education Agencies (LEA). The Local Education Plan offers similar health benefits as the State Plan which are administered by the State's contracted TPAs.

The Local Education Plan enrollment has approximately 56,000 employees/retirees with a total of over 112,000 covered lives. Most of the employees are teachers; the balance is comprised of administrators, cafeteria workers, maintenance and other support personnel. The State, through a budget funding formula, pays the LEA 45% of the aggregate average premium for each instructional staff and 30% of the aggregate average premium for each non-instructional staff. Approximately $400 million in medical Claims and $167 million in pharmacy and mental health Claims were paid under these Plan options during Plan year 2019.

In addition to health insurance coverage, LEAs may participate in the same dental and vision products as State Plan Members.

Local Government Group Insurance Plan

The Local Government Group Insurance Plan is governed by the Local Government Insurance Committee and is also a financially separate, self-funded program available to employees of 382 local governments or quasi-governmental entities in Tennessee who elect to secure health insurance coverage through this Plan. The health benefits and their administrators are identical to those under the Local Education Plan.

The Local Government Plan enrollment is approximately 17,000 employees with a total of over 27,000 covered lives. Approximately $104 million in medical Claims and $41 million in pharmacy and mental health claims were paid under these Plan options during Plan year 2019. The State does not provide any funding to participating Local Government Agencies.

In addition to health insurance coverage, Local Government Agencies may participate in the same dental and vision products as State Plan Members.

Other Recent, Relevant Initiatives and Developments

The Plans strive to provide comprehensive, affordable, dependable and sustainable health benefits for our 288,000 Members with the aim of keeping expenditures at or below annual projected medical trend. Like all employers, we continue to search for, and implement, plan design concepts that deliver best value: "bending the cost curve" and improving quality for our Members.

Population Health:
Because of our heavy chronic disease burden, population health has been at the core of our Plan design since 2011. Reducing health risk and improving clinical outcomes is the focus for the population health initiative and continues to be the driving force in determining future population health incentives. Population health program availability differs between the State, Local Education, and Local Government Plans.

Tennessee Health Care Innovation Initiative:

The State has launched a state-wide initiative to transition its healthcare payment system to better reward patient-centered, high-value health care outcomes for all Tennesseans. The Tennessee Health Care Innovation Initiative (THCII) is led by the Division of TennCare and the Division of Benefits Administration (BA), and engages a broad group of stakeholders, including the largest private insurers in Tennessee and leading Tennessee healthcare providers.

Following a thorough review of outcomes-based payment strategies, and with the input of stakeholders, the THCII has pursued complementary payment strategies including a retrospective episode-based payment strategy to reward providers for providing high-quality and efficient care for acute and chronic medical and mental health treatments and conditions. BA has engaged in the episodes of care model and has to date implemented eleven episodes with the current TPAs. Additional information about this initiative is available at https://www.tn.gov/tenncare/health-care-innovation.html.

1.1.2. The maximum liability for the resulting contract will be determined through the best evaluated cost proposal and estimated cost associated with this service. The maximum liability will exceed one dollar ($1.00).

1.2. **Scope of Service, Contract Period, & Required Terms and Conditions**

The RFP Attachment 6.6., *Pro Forma* Contract details the State's requirements:

- Scope of Services and Deliverables (Section A);
- Contract Period (Section B);
- Payment Terms (Section C);
- Standard Terms and Conditions (Section D); and,
- Special Terms and Conditions (Section E).

The *pro forma* contract substantially represents the contract document that the successful Respondent must sign.

1.3. **Nondiscrimination**

No person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of a Contract pursuant to this RFP 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, Tennessee state constitutional, or statutory law. The Contractor pursuant to this RFP shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

1.4. **RFP Communications**

1.4.1. The State has assigned the following RFP identification number that must be referenced in all communications regarding this RFP:

RFP # 31786-00148

1.4.2. **Unauthorized contact about this RFP with employees or officials of the State of Tennessee except as detailed below may result in disqualification from consideration under this procurement process.**

1.4.2.1. Prospective Respondents must direct communications concerning this RFP to the following person designated as the Solicitation Coordinator:

Seannalyn Brandmeir
Procurement and Contracts Director
Tennessee Department of Finance & Administration, Division of Benefits Administration
312 Rosa L. Parks Avenue, Suite 1900

Nashville, Tennessee 37243
Seannalyn.Brandmeir@tn.gov
Telephone: 615.532.4598
Fax: 615.253.8556

Heather Pease
Benefits and Contracting Assistant Director
Tennessee Department of Finance & Administration, Division of Benefits Administration
312 Rosa L. Parks Avenue, Suite 1900
Nashville, Tennessee 37243
heather.pease@tn.gov
Telephone: 615.253.1652
Fax: 615.253.8556

1.4.2.2. Notwithstanding the foregoing, Prospective Respondents may alternatively contact:

a. staff of the Governor's Office of Diversity Business Enterprise for assistance available to minority-owned, woman-owned, service-disabled veteran-owned, businesses owned by persons with disabilities, and small businesses as well as general, public information relating to this RFP (visit https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/governor-s-office-of-diversity-business-enterprise--godbe--/godbe-general-contacts.html for contact information); and

b. the following individual designated by the State to coordinate compliance with the nondiscrimination requirements of the State of Tennessee, Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, and associated federal regulations:

Lucian Geise, General Counsel
Tennessee Department of Finance & Administration
312 Rosa L. Parks Avenue, Suite 2000 Nashville, Tennessee 37243
Phone Number: 615-532-9617
Fax:615-532-8532
FA.CivilRights@tn.gov

1.4.3. Only the State's official, written responses and communications with Respondents are binding with regard to this RFP. Oral communications between a State official and one or more Respondents are unofficial and non-binding.

1.4.4. Potential Respondents must ensure that the State receives all written questions and comments, including questions and requests for clarification, no later than the Written Questions & Comments Deadline detailed in the RFP Section 2, Schedule of Events.

1.4.5. Respondents must assume the risk of the method of dispatching any communication or response to the State. The State assumes no responsibility for delays or delivery failures resulting from the Respondent's method of dispatch. Actual or digital "postmarking" of a communication or response to the State by a specified deadline is not a substitute for the State's actual receipt of a communication or response.

1.4.6. The State will convey all official responses and communications related to this RFP to the prospective Respondents from whom the State has received a Notice of Intent to Respond (refer to RFP Section 1.8).

1.4.7. The State reserves the right to determine, at its sole discretion, the method of conveying official, written responses and communications related to this RFP. Such written communications may

be transmitted by mail, hand-delivery, facsimile, electronic mail, Internet posting, or any other means deemed reasonable by the State. For internet posting, please refer to the following website: https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/supplier-information/request-for-proposals--rfp--opportunities1.html.

1.4.8. The State reserves the right to determine, at its sole discretion, the appropriateness and adequacy of responses to written comments, questions, and requests related to this RFP. The State's official, written responses will constitute an amendment of this RFP.

1.4.9. Any data or factual information provided by the State (in this RFP, an RFP amendment or any other communication relating to this RFP) is for informational purposes only. The State will make reasonable efforts to ensure the accuracy of such data or information, however it is the Respondent's obligation to independently verify any data or information provided by the State. The State expressly disclaims the accuracy or adequacy of any information or data that it provides to prospective Respondents.

1.5. Assistance to Respondents With a Handicap or Disability

Prospective Respondents with a handicap or disability may receive accommodation relating to the communication of this RFP and participating in the RFP process. Prospective Respondents may contact the Solicitation Coordinator to request such reasonable accommodation no later than the Disability Accommodation Request Deadline detailed in the RFP Section 2, Schedule of Events.

1.6. Respondent Required Review & Waiver of Objections

1.6.1. Each prospective Respondent must carefully review this RFP, including but not limited to, attachments, the RFP Attachment 6.6., *Pro Forma* Contract, and any amendments, for questions, comments, defects, objections, or any other matter requiring clarification or correction (collectively called "questions and comments").

1.6.2. Any prospective Respondent having questions and comments concerning this RFP must provide them in writing to the State no later than the Written Questions & Comments Deadline detailed in the RFP Section 2, Schedule of Events.

1.6.3. Protests based on any objection to the RFP shall be considered waived and invalid if the objection has not been brought to the attention of the State, in writing, by the Written Questions & Comments Deadline.

1.7. Pre-Response Conference

A Pre-response Conference will be held at the time and date detailed in the RFP Section 2, Schedule of Events. Pre-response Conference attendance is not mandatory, and prospective Respondents may be limited to a maximum number of attendees depending upon overall attendance and space limitations.

Webex information:
Webex meeting *(active link to web address)*
Meeting number (access code): 161 931 6060
Meeting password: 3sfHEMjUs34

The purpose of the conference is to discuss the RFP scope of goods or services. The State will entertain questions, however prospective Respondents must understand that the State's oral response to any question at the Pre-response Conference shall be unofficial and non-binding. Prospective Respondents must submit all questions, comments, or other concerns regarding the RFP in writing prior to the Written Questions & Comments Deadline date detailed in the RFP Section 2, Schedule of Events. The State will send the official response to these questions and comments to prospective Respondents from whom the State has received a Notice of Intent to respond as indicated in RFP Section 1.8 and on the date detailed in the RFP Section 2, Schedule of Events.

1.8. Notice of Intent to Respond

Before the Notice of Intent to Respond Deadline detailed in the RFP Section 2, Schedule of Events, prospective Respondents should submit to the Solicitation Coordinator a Notice of Intent to Respond (in the form of a simple e-mail or other written communication). Such notice should include the following information:

- the business or individual's name (as appropriate);
- a contact person's name and title; and
- the contact person's mailing address, telephone number, facsimile number, and e-mail address.

A Notice of Intent to Respond creates no obligation and is not a prerequisite for submitting a response, however, it is necessary to ensure receipt of any RFP amendments or other notices and communications relating to this RFP.

1.9. Response Deadline

A Respondent must ensure that the State receives a response no later than the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events. The State will not accept late responses, and a Respondent's failure to submit a response before the deadline will result in disqualification of the response. It is the responsibility of the Respondent to ascertain any additional security requirements with respect to packaging and delivery to the State of Tennessee. Respondents should be mindful of any potential delays due to security screening procedures, weather, or other filing delays whether foreseeable or unforeseeable.

2. RFP SCHEDULE OF EVENTS

2.1. The following RFP Schedule of Events represents the State's best estimate for this RFP.

EVENT	TIME (central time zone)	DATE
1. RFP Issued		November 25, 2020
2. Disability Accommodation Request Deadline	2:00 p.m.	December 2, 2020
3. Pre-response Conference	2:30 p.m.	December 4, 2020
4. Notice of Intent to Respond Deadline	2:00 p.m.	December 7, 2020
5. Written "Questions & Comments" Deadline	2:00 p.m.	December 11, 2020
6. State Response to Written "Questions & Comments"		January 8, 2021
7. 2nd Round Written "Questions & Comments" ***NOTE: Vendors may submit no more than 5 questions to the State in the 2nd round of Written Questions and Comments.**	2:00 p.m.	January 15, 2021
8. Deadline to Submit Network and Claims Information to Aon		January 28, 2021
9. State Response to 2nd Round Written "Questions & Comments"		January 29, 2021
10. Response Deadline	2:00 p.m.	February 12, 2021
11. State Opening of Cost Proposals	2:00 p.m.	February 12, 2021
12. State Completion of Technical Response Evaluations		March 9, 2021
13. Scoring of Cost Proposals	2:00 p.m.	March 9, 2021
14. State Notice of Intent to Award Released AND RFP Files Opened for Public Inspection	3:00 p.m.	April 22, 2021
15. End of Open File Period		April 29, 2021
16. State sends contract to Contractor for signature		May 3, 2021
17. Contractor Signature Deadline	2:00 p.m.	May 7, 2021

***NOTE: Vendors may submit no more than 5 questions to the State in the 2nd round of Written Questions and Comments. The goal is to clarify any outstanding questions or concerns from the first round or any questions a Respondent previously overlooked.**

2.2. **The State reserves the right, at its sole discretion, to adjust the RFP Schedule of Events as it deems necessary.** Any adjustment of the Schedule of Events shall constitute an RFP amendment, and the State will communicate such to prospective Respondents from whom the State has received a Notice of Intent to Respond (refer to section 1.8).

3. RESPONSE REQUIREMENTS

3.1. Response Form

A response to this RFP must consist of two parts, a Technical Response and a Cost Proposal.

3.1.1. **Technical Response**. RFP Attachment 6.2., Technical Response & Evaluation Guide provides the specific requirements for submitting a response. This guide includes mandatory requirement items, general qualifications and experience items, and technical qualifications, experience, and approach items all of which must be addressed with a written response and, in some instances, additional documentation.

NOTICE: A technical response must not include any pricing or cost information. If any pricing or cost information amounts of any type (even pricing relating to other projects) is included in any part of the technical response, the state may deem the response to be non-responsive and reject it.

3.1.1.1. A Respondent must use the RFP Attachment 6.2., Technical Response & Evaluation Guide to organize, reference, and draft the Technical Response by duplicating the attachment, adding appropriate page numbers as required, and using the guide as a table of contents covering the Technical Response.

3.1.1.2. A response should be economically prepared, with emphasis on completeness and clarity, and should NOT exceed 200 pages in length (maps, graphs, charts, as noted and included as an appendix will not count against this page limit). A response, as well as any reference material presented, must be written in English and must be written on standard 8 ½" x 11" pages (although oversize exhibits are permissible) and all text must be at least a 12 point font. All response pages must be numbered.

3.1.1.3. All information and documentation included in a Technical Response should correspond to or address a specific requirement detailed in the RFP Attachment 6.2., Technical Response & Evaluation Guide. All information must be incorporated into a response to a specific requirement and clearly referenced. Any information not meeting these criteria will be deemed extraneous and will not contribute to evaluations.

3.1.1.4. The State may determine a response to be non-responsive and reject it if:

a. the Respondent fails to organize and properly reference the Technical Response as required by this RFP and the RFP Attachment 6.2., Technical Response & Evaluation Guide; or

b. the Technical Response document does not appropriately respond to, address, or meet all of the requirements and response items detailed in the RFP Attachment 6.2., Technical Response & Evaluation Guide.

3.1.2. **Cost Proposal**. A Cost Proposal must be recorded on an exact duplicate of the RFP Attachment 6.3., Cost Proposal & Scoring Guide.

NOTICE: If a Respondent fails to submit a cost proposal exactly as required, the State may deem the response to be non-responsive and reject it.

3.1.2.1. A Respondent must only record the proposed cost exactly as required by the RFP Attachment 6.3., Cost Proposal & Scoring Guide and must NOT record any other rates, amounts, or information.

3.1.2.2. The proposed cost shall incorporate ALL costs for services under the contract for the total contract period, including any renewals or extensions.

3.1.2.3. A Respondent must sign and date the Cost Proposal.

3.1.2.4. A Respondent must submit the Cost Proposal to the State in a sealed package separate from the Technical Response (as detailed in RFP Sections 3.2.3., *et seq.*).

3.2. Response Delivery

3.2.1. A Respondent must ensure that both the original Technical Response and Cost Proposal documents meet all form and content requirements, including all required signatures, as detailed within this RFP, as may be amended.

3.2.2. A Respondent must submit their responses as specified in one of the two formats below.

3.2.2.1. Digital Media Submission

3.2.2.1.1. Technical Response
The Technical Response document should be in the form of one (1) digital document in "PDF" format properly recorded on its own otherwise blank, standard USB flash drive and should be clearly identified as the:

"RFP # 31786-00148 TECHNICAL RESPONSE ORIGINAL"

and two (2) digital copies of the Technical Response each in the form of one (1) digital document with **separate individual corresponding appendices or exhibits** in "PDF" format properly recorded on its own otherwise blank, USB flash drive labeled:

"RFP # 31786-00148 TECHNICAL RESPONSE COPY"

The customer references should be delivered by each reference in accordance with RFP Attachment 6.2, Section B.17.

3.2.2.1.2. Cost Proposal

The Cost Proposal should be in the form of one (1) digital document in "XLS" format properly recorded on a separate, otherwise blank, USB flash drive clearly labeled:

"RFP #31786-00148 COST PROPOSAL"

An electronic or facsimile signature, as applicable, on the Cost Proposal is acceptable.

3.2.2.2. E-Mail Submission

3.2.2.2.1. Technical Response

The Technical Response document should be in the form of one (1) digital document in "PDF" format or other easily accessible digital format attached to an e-mail to the Solicitation Coordinator. Both the subject and file name should both be clearly identified as follows:

"RFP #31786-00148 TECHNICAL RESPONSE"

The customer references should be delivered by each reference in accordance with RFP Attachment 6.2, Section B.17.

3.2.2.2.2. Cost Proposal:

The Cost Proposal should be in the form of one (1) digital document in "XLS" format or other easily accessible digital format attached to an e-mail to the Solicitation Coordinator. Both the subject and file name should both be clearly identified as follows:

"RFP #31786-00148 COST PROPOSAL"

An electronic or facsimile signature, as applicable, on the Cost Proposal is acceptable.

3.2.3. For e-mail submissions, the Technical Response and Cost Proposal documents must be dispatched to the Solicitation Coordinator in separate e-mail messages. For digital media submissions, a Respondent must separate, seal, package, and label the documents and copies for delivery as follows:

3.2.3.1. The Technical Response copies must be placed in a sealed package that is clearly labeled:

"DO NOT OPEN… RFP # 31786-00148 TECHNICAL RESPONSE FROM [RESPONDENT LEGAL ENTITY NAME]"

3.2.3.2. The Cost Proposal must be placed in a separate, sealed package that is clearly labeled:

"DO NOT OPEN… RFP # 31786-00148 COST PROPOSAL FROM [RESPONDENT LEGAL ENTITY NAME]"

3.2.3.3. The separately, sealed Technical Response and Cost Proposal components may be enclosed in a larger package for mailing or delivery, provided that the outermost package is clearly labeled:

"RFP # 31786-00148 SEALED TECHNICAL RESPONSE & SEALED COST PROPOSAL FROM [RESPONDENT LEGAL ENTITY NAME]"

3.2.3.4 Any Respondent wishing to submit a Response in a format other than digital may do so by contacting the Solicitation Coordinator.

3.2.4. A Respondent must ensure that the State receives a response no later than the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events at the following address:

Seannalyn Brandmeir
Procurement and Contract Director
Tennessee Department of Finance & Administration, Division of Benefits Administration
312 Rosa L. Parks Avenue, Suite 1900
Nashville, Tennessee 37243
Seannalyn.Brandmeir@tn.gov
Telephone: 615.532.4598
Fax: 615.253.8556

3.2.5. A Respondent must ensure that Aon receives all network and claims information no later than the Deadline time and date detailed in the RFP Section 2, Schedule of Events. Information must go to the following individuals and email addresses:

Discount Analysis information (Refer to Appendix 7.1):

Shelley Zhao - shelley.s.zhao1@aon.com
Bob Tate - bob.tate1@aon.com

Provider Disruption Analysis:
hnapdmbx@aon.com

3.3. **Response & Respondent Prohibitions**

3.3.1. A response must not include alternate contract terms and conditions. If a response contains such terms and conditions, the State, at its sole discretion, may determine the response to be a non-responsive counteroffer and reject it.

3.3.2. A response must not restrict the rights of the State or otherwise qualify either the offer to deliver goods or provide services as required by this RFP or the Cost Proposal. If a response restricts the rights of the State or otherwise qualifies either the offer to deliver goods or provide services as required by this RFP or the Cost Proposal, the State, at its sole discretion, may determine the response to be a non-responsive counteroffer and reject it.

3.3.3. A response must not propose alternative goods or services (*i.e*., offer services different from those requested and required by this RFP) unless expressly requested in this RFP. The State may consider a response of alternative goods or services to be non-responsive and reject it.

3.3.4. A Cost Proposal must be prepared and arrived at independently and must not involve any collusion between Respondents. The State will reject any Cost Proposal that involves collusion, consultation, communication, or agreement between Respondents. Regardless of the time of detection, the State will consider any such actions to be grounds for response rejection or contract termination.

3.3.5. A Respondent must not provide, for consideration in this RFP process or subsequent contract negotiations, any information that the Respondent knew or should have known was materially incorrect. If the State determines that a Respondent has provided such incorrect information, the State will deem the Response non-responsive and reject it.

3.3.6. A Respondent must not submit more than one Technical Response and one Cost Proposal in response to this RFP, except as expressly requested by the State in this RFP. If a Respondent submits more than one Technical Response or more than one Cost Proposal, the State will deem all of the responses non-responsive and reject them.

3.3.7. A Respondent must not submit a response as a prime contractor while also permitting one or more other Respondents to offer the Respondent as a subcontractor in their own responses. Such may result in the disqualification of all Respondents knowingly involved. This restriction does not, however, prohibit different Respondents from offering the same subcontractor as a part of their responses (provided that the subcontractor does not also submit a response as a prime contractor).

3.3.8. The State shall not consider a response from an individual who is, or within the past six (6) months has been, a State employee. For purposes of this RFP:

3.3.8.1. An individual shall be deemed a State employee until such time as all compensation for salary, termination pay, and annual leave has been paid;

3.3.8.2. A contract with or a response from a company, corporation, or any other contracting entity in which a controlling interest is held by any State employee shall be considered to be a contract with or proposal from the employee; and

3.3.8.3. A contract with or a response from a company, corporation, or any other contracting entity that employs an individual who is, or within the past six (6) months has been, a State employee shall not be considered a contract with or a proposal from the employee and shall not constitute a prohibited conflict of interest.

3.3.9. This RFP is also subject to Tenn. Code Ann. § 12-4-101—105.

3.4. Response Errors & Revisions

A Respondent is responsible for any and all response errors or omissions. A Respondent will not be allowed to alter or revise response documents after the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events unless such is formally requested, in writing, by the State.

3.5. Response Withdrawal

A Respondent may withdraw a submitted response at any time before the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events by submitting a written request signed by an authorized Respondent representative. After withdrawing a response, a Respondent may submit another response at any time before the Response Deadline. After the Response Deadline, a Respondent may only withdraw all or a portion of a response where the enforcement of the response would impose an unconscionable hardship on the Respondent.

3.6. Additional Services

If a response offers goods or services in addition to those required by and described in this RFP, the State, at its sole discretion, may add such services to the contract awarded as a result of this RFP. Notwithstanding the foregoing, a Respondent must not propose any additional cost amounts or rates for additional goods or services. Regardless of any additional services offered in a response, the Respondent's Cost Proposal must only record the proposed cost as required in this RFP and must not record any other rates, amounts, or information.

NOTICE: If a Respondent fails to submit a Cost Proposal exactly as required, the State may deem the response non-responsive and reject it.

3.7. Response Preparation Costs

The State will <u>not</u> pay any costs associated with the preparation, submittal, or presentation of any response.

4. GENERAL CONTRACTING INFORMATION & REQUIREMENTS

4.1. RFP Amendment

The State at its sole discretion may amend this RFP, in writing, at any time prior to contract award. However, prior to any such amendment, the State will consider whether it would negatively impact the ability of potential Respondents to meet the response deadline and revise the RFP Schedule of Events if deemed appropriate. If an RFP amendment is issued, the State will convey it to potential Respondents who submitted a Notice of Intent to Respond (refer to RFP Section 1.8). A response must address the final RFP (including its attachments) as amended.

4.2. RFP Cancellation

The State reserves the right, at its sole discretion, to cancel the RFP or to cancel and reissue this RFP in accordance with applicable laws and regulations.

4.3. State Right of Rejection

4.3.1. Subject to applicable laws and regulations, the State reserves the right to reject, at its sole discretion, any and all responses.

4.3.2. The State may deem as non-responsive and reject any response that does not comply with all terms, conditions, and performance requirements of this RFP. Notwithstanding the foregoing, the State reserves the right to waive, at its sole discretion, minor variances from full compliance with this RFP. If the State waives variances in a response, such waiver shall not modify the RFP requirements or excuse the Respondent from full compliance, and the State may hold any resulting Contractor to strict compliance with this RFP.

4.4. Assignment & Subcontracting

4.4.1. The Contractor may not subcontract, transfer, or assign any portion of the Contract awarded as a result of this RFP without prior approval of the State. The State reserves the right to refuse approval, at its sole discretion, of any subcontract, transfer, or assignment.

4.4.2. If a Respondent intends to use subcontractors, the response to this RFP must specifically identify the scope and portions of the work each subcontractor will perform (refer to RFP Attachment 6.2., Section B, General Qualifications & Experience Item B.12.).

4.4.3. Subcontractors identified within a response to this RFP will be deemed as approved by the State unless the State expressly disapproves one or more of the proposed subcontractors prior to signing the Contract.

4.4.4. After contract award, a Contractor may only substitute an approved subcontractor at the discretion of the State and with the State's prior, written approval.

4.4.5. Notwithstanding any State approval relating to subcontracts, the Respondent who is awarded a contract pursuant to this RFP will be the prime contractor and will be responsible for all work under the Contract.

4.5. Right to Refuse Personnel or Subcontractors

The State reserves the right to refuse, at its sole discretion and notwithstanding any prior approval, any personnel of the prime contractor or a subcontractor providing goods or services in the performance of a contract resulting from this RFP. The State will document in writing the reason(s) for any rejection of personnel.

4.6. Insurance

The State will require the awarded Contractor to provide a Certificate of Insurance issued by an insurance company licensed or authorized to provide insurance in the State of Tennessee. Each Certificate of Insurance shall indicate current insurance coverages meeting minimum requirements as may be specified by this RFP. A failure to provide a current, Certificate of Insurance will be considered a material breach and grounds for contract termination.

4.7. Professional Licensure and Department of Revenue Registration

4.7.1. All persons, agencies, firms, or other entities that provide legal or financial opinions, which a Respondent provides for consideration and evaluation by the State as a part of a response to this RFP, shall be properly licensed to render such opinions.

4.7.2. Before the Contract resulting from this RFP is signed, the apparent successful Respondent (and Respondent employees and subcontractors, as applicable) must hold all necessary or appropriate business or professional licenses to provide the goods or services as required by the contract. The State may require any Respondent to submit evidence of proper licensure.

4.7.3. Before the Contract resulting from this RFP is signed, the apparent successful Respondent must be registered with the Tennessee Department of Revenue for the collection of Tennessee sales and use tax. The State shall not award a contract unless the Respondent provides proof of such registration or provides documentation from the Department of Revenue that the Contractor is exempt from this registration requirement. The foregoing is a mandatory requirement of an award of a contract pursuant to this solicitation. To register, please visit the Department of Revenue's Tennessee Taxpayer Access Point (TNTAP) website for Online Registration and the Vendor Contract Questionnaire. These resources are available at the following: https://tntap.tn.gov/eservices/_/#1

4.8. Disclosure of Response Contents

4.8.1. All materials submitted to the State in response to this RFP shall become the property of the State of Tennessee. Selection or rejection of a response does not affect this right. By submitting a response, a Respondent acknowledges and accepts that the full response contents and associated documents will become open to public inspection in accordance with the laws of the State of Tennessee.

4.8.2. The State will hold all response information, including both technical and cost information, in confidence during the evaluation process.

4.8.3. Upon completion of response evaluations, indicated by public release of a Notice of Intent to Award, the responses and associated materials will be open for review by the public in accordance with Tenn. Code Ann. § 10-7-504(a)(7).

4.9. Contract Approval and Contract Payments

4.9.1. After contract award, the Contractor who is awarded the contract must submit appropriate documentation with the Department of Finance and Administration, Division of Accounts.

4.9.2. This RFP and its contractor selection processes do not obligate the State and do not create rights, interests, or claims of entitlement in either the Respondent with the apparent best-evaluated response or any other Respondent. State obligations pursuant to a contract award shall commence only after the Contract is signed by the State agency head and the Contractor and after the Contract is approved by all other state officials as required by applicable laws and regulations.

4.9.3. No payment will be obligated or made until the relevant Contract is approved as required by applicable statutes and rules of the State of Tennessee.

4.9.3.1. The State shall not be liable for payment of any type associated with the Contract resulting from this RFP (or any amendment thereof) or responsible for any goods delivered or services rendered by the Contractor, even goods delivered or services rendered in good faith and even if the Contractor is orally directed to proceed with the delivery of goods or the rendering of services, if it occurs before the Contract Effective Date or after the Contract Term.

4.9.3.2. All payments relating to this procurement will be made in accordance with the Payment Terms and Conditions of the Contract resulting from this RFP (refer to RFP Attachment 6.6., *Pro Forma* Contract, Section C).

4.9.3.3. If any provision of the Contract provides direct funding or reimbursement for the competitive purchase of goods or services as a component of contract performance or otherwise provides for the reimbursement of specified, actual costs, the State will employ all reasonable means and will require all such documentation that it deems necessary to ensure that such purchases were competitive and costs were reasonable, necessary, and actual. The Contractor shall provide reasonable assistance and access related to such review. Further, the State shall not remit, as funding or reimbursement pursuant to such provisions, any amounts that it determines do not represent reasonable, necessary, and actual costs.

4.10. Contractor Performance

The Contractor who is awarded a contract will be responsible for the delivery of all acceptable goods or the satisfactory completion of all services set out in this RFP (including attachments) as may be amended. All goods or services are subject to inspection and evaluation by the State. The State will employ all reasonable means to ensure that goods delivered or services rendered are in compliance with the Contract, and the Contractor must cooperate with such efforts.

4.11. Contract Amendment

After Contract award, the State may request the Contractor to deliver additional goods or perform additional services within the general scope of the Contract and this RFP, but beyond the specified Scope, and for which the Contractor may be compensated. In such instances, the State will provide the Contractor a written description of the additional goods or services. The Contractor must respond to the State with a time schedule for delivering the additional goods or accomplishing the additional services based on the compensable units included in the Contractor's response to this RFP. If the State and the Contractor reach an agreement regarding the goods or services and associated compensation, such agreement must be effected by means of a contract amendment. Further, any such amendment requiring additional goods or services must be signed by both the State agency head and the Contractor and must be approved by other state officials as required by applicable statutes, rules, policies and procedures of the State of Tennessee. The Contractor must not provide additional goods or render additional services until the State has issued a written contract amendment with all required approvals.

4.12. Severability

If any provision of this RFP is declared by a court to be illegal or in conflict with any law, said decision will not affect the validity of the remaining RFP terms and provisions, and the rights and obligations of the State and Respondents will be construed and enforced as if the RFP did not contain the particular provision held to be invalid.

4.13. Next Ranked Respondent

The State reserves the right to initiate negotiations with the next ranked Respondent should the State cease doing business with any Respondent selected via this RFP process.

5. EVALUATION & CONTRACT AWARD

5.1. Evaluation Categories & Maximum Points

The State will consider qualifications, experience, technical approach, and cost in the evaluation of responses and award points in each of the categories detailed below (up to the maximum evaluation points indicated) to each response deemed by the State to be responsive.

EVALUATION CATEGORY	MAXIMUM POINTS POSSIBLE
General Qualifications & Experience (refer to RFP Attachment 6.2., Section B)	**5**
Technical Qualifications, Experience & Approach (refer to RFP Attachment 6.2., Section C)	**35**
Technical Qualifications, Network Analysis (refer to RFP Attachment 6.2.) Section D Parts 1. Provider Network Q&A 2. Provider Network Analysis Efficient & Broad 3. Disruption Analysis	 **5** **10** **10**
Cost Proposal (refer to RFP Attachment 6.3.) Parts: 1. Total Costs (admin & claims) 2. Trend Guarantee 3. Expert Medical Opinion	 **29** **5** **1**

5.2. Evaluation Process

The evaluation process is designed to award the contract resulting from this RFP not necessarily to the Respondent offering the lowest cost, but rather to the Respondent deemed by the State to be responsive and responsible who offers the best combination of attributes based upon the evaluation criteria. ("Responsive Respondent" is defined as a Respondent that has submitted a response that conforms in all material respects to the RFP. "Responsible Respondent" is defined as a Respondent that has the capacity in all respects to perform fully the contract requirements, and the integrity and reliability which will assure good faith performance.)

5.2.1. **Technical Response Evaluation.** The Solicitation Coordinator and the Proposal Evaluation Team (consisting of three (3) or more State employees) will use the RFP Attachment 6.2., Technical Response & Evaluation Guide to manage the Technical Response Evaluation and maintain evaluation records.

5.2.1.1. The State reserves the right, at its sole discretion, to request Respondent clarification of a Technical Response or to conduct clarification discussions with any or all Respondents. Any such clarification or discussion will be limited to specific sections of the response identified by the State. The subject Respondent must put any resulting clarification in writing as may be required and in accordance with any deadline imposed by the State.

5.2.1.2. The Solicitation Coordinator will review each Technical Response to determine compliance with RFP Attachment 6.2., Technical Response & Evaluation Guide, Section A— Mandatory Requirements. If the Solicitation Coordinator determines that a

response failed to meet one or more of the mandatory requirements, the Proposal Evaluation Team will review the response and document the team's determination of whether:

a. the response adequately meets RFP requirements for further evaluation;

b. the State will request clarifications or corrections for consideration prior to further evaluation; or,

c. the State will determine the response to be non-responsive to the RFP and reject it.

5.2.1.3. Proposal Evaluation Team members will independently evaluate each Technical Response (that is responsive to the RFP) against the evaluation criteria in this RFP, and will score each in accordance with the RFP Attachment 6.2., Technical Response & Evaluation Guide.

5.2.1.4. For each response evaluated, the Solicitation Coordinator will calculate the average of the Proposal Evaluation Team member scores for RFP Attachment 6.2., Technical Response & Evaluation Guide, and record each average as the response score for the respective Technical Response section.

5.2.1.5. Before Cost Proposals are opened, the Proposal Evaluation Team will review the Technical Response Evaluation record and any other available information pertinent to whether or not each Respondent is responsive and responsible. If the Proposal Evaluation Team identifies any Respondent that does not meet the responsive and responsible thresholds such that the team would not recommend the Respondent for Cost Proposal Evaluation and potential contract award, the team members will fully document the determination.

5.2.2. **Cost Proposal Evaluation.** Once the Solicitation Coordinator has determined that the Respondent is a Responsible Respondent as defined in Section 5.2, the Solicitation Coordinator will open for evaluation the Cost Proposal of each Respondent deemed by the State to be responsible for an initial check for completion of the cost proposals according to the directions contained in RFP Attachment 6.3. Cost Proposal & Scoring Guide.

This information for each responsible Respondent will be forwarded to an independent actuarial firm under contract with the Department of Finance & Administration, Division of Benefits Administration based on the RFP Schedule of Events. Claims analysis will be done by an independent actuarial firm and Benefits Administration staff not associated with the evaluation team. The Solicitation Coordinator is the only person during the evaluation that will have access to both the Technical Response and the Cost Proposal information. At no time, will Cost Proposal information be provided to individual evaluation team members

The actuarial firm will also check for the completion of the cost proposals according to the directions contained in RFP Attachment 6.3. Cost Proposal & Scoring Guide. If any questions surface regarding the completion of the forms, the firm is instructed to contact the Solicitation Coordinator with the concern and the Solicitation Coordinator will take appropriate steps to determine the Proposal's responsiveness. The results from the Claims analysis will be provided to the Solicitation Coordinator. The Solicitation Coordinator will calculate and record each Cost Proposal score in accordance with the RFP Attachment 6.3. Cost Proposal & Scoring Guide.

5.2.3. **Total Response Score.** The Solicitation Coordinator will calculate the sum of the Technical Response section scores and the Cost Proposal score and record the resulting number as the total score for the subject Response (refer to RFP Attachment 6.5., Score Summary Matrix).

5.3. Contract Award Process

5.3.1 The Solicitation Coordinator will submit the Proposal Evaluation Team determinations and scores to Benefits Administration's executive director for consideration along with any other relevant information that might be available and pertinent to contract award.

5.3.2. Benefits Administration's executive director may concur with the apparent best-evaluated Response recommendation. To effect a contract award to a Respondent other than the one receiving the highest evaluation process score, the head of the procuring agency must provide written justification and obtain the written approval of the Chief Procurement Officer and the Comptroller of the Treasury.

5.3.3. Benefits Administration will present the apparent best-evaluated Response recommendation before the State, Local Education, and Local Government Insurance Committees, as applicable, for approval to enter into a contract with the best-evaluated Respondent.

5.3.4. The State will issue a Notice of Intent to Award identifying the apparent best-evaluated response and make the RFP files available for public inspection at the time and date specified in the RFP Section 2, Schedule of Events.

NOTICE: The Notice of Intent to Award shall not create rights, interests, or claims of entitlement in either the apparent best-evaluated Respondent or any other Respondent.

5.3.5. The Respondent identified as offering the apparent best-evaluated response must sign a contract drawn by the State pursuant to this RFP. The Contract shall be substantially the same as the RFP Attachment 6.6., *Pro Forma* Contract. The Respondent must sign the contract by the Contractor Signature Deadline detailed in the RFP Section 2, Schedule of Events. If the Respondent fails to provide the signed Contract by this deadline, the State may determine that the Respondent is non-responsive to this RFP and reject the response.

5.3.6. Notwithstanding the foregoing, the State may, at its sole discretion, entertain limited terms and conditions or pricing negotiations prior to Contract signing and, as a result, revise the *pro forma* contract terms and conditions or performance requirements in the State's best interests, PROVIDED THAT such revision of terms and conditions or performance requirements shall NOT materially affect the basis of response evaluations or negatively impact the competitive nature of the RFP and contractor selection process.

5.3.7. If the State determines that a response is non-responsive and rejects it after opening Cost Proposals, the Solicitation Coordinator will re-calculate scores for each remaining responsive Cost Proposal to determine (or re-determine) the apparent best-evaluated response.

RFP ATTACHMENT 6.1.

RFP # 31786-00148 STATEMENT OF CERTIFICATIONS AND ASSURANCES

The Respondent must sign and complete the Statement of Certifications and Assurances below as required, and it must be included in the Technical Response (as required by RFP Attachment 6.2., Technical Response & Evaluation Guide, Section A, Item A.1.).

The Respondent does, hereby, expressly affirm, declare, confirm, certify, and assure ALL of the following:

1. The Respondent will comply with all of the provisions and requirements of the RFP.
2. The Respondent will provide all services as defined in the Scope of the RFP Attachment 6.6., *Pro Forma* Contract for the total Contract Term.
3. The Respondent, except as otherwise provided in this RFP, accepts and agrees to all terms and conditions set out in the RFP Attachment 6.6., *Pro Forma* Contract.
4. The Respondent acknowledges and agrees that a contract resulting from the RFP shall incorporate, by reference, all proposal responses as a part of the Contract.
5. The Respondent will comply with:
   (a) the laws of the State of Tennessee;
   (b) Title VI of the federal Civil Rights Act of 1964;
   (c) Title IX of the federal Education Amendments Act of 1972;
   (d) the Equal Employment Opportunity Act and the regulations issued there under by the federal government; and,
   (e) the Americans with Disabilities Act of 1990 and the regulations issued there under by the federal government.
6. To the knowledge of the undersigned, the information detailed within the response submitted to this RFP is accurate.
7. The response submitted to this RFP was independently prepared, without collusion, under penalty of perjury.
8. No amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Respondent in connection with this RFP or any resulting contract.
9. Both the Technical Response and the Cost Proposal submitted in response to this RFP shall remain valid for at least 120 days subsequent to the date of the Cost Proposal opening and thereafter in accordance with any contract pursuant to the RFP.
10. The Respondent affirms the following statement, as required by the Iran Divestment Act Tenn. Code Ann. § 12-12-111: "By submission of this bid, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of its knowledge and belief that each bidder is not on the list created pursuant to §12-12-106." For reference purposes, the list is currently available online at: https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/library-/public-information-library.html.

By signing this Statement of Certifications and Assurances, below, the signatory also certifies legal authority to bind the proposing entity to the provisions of this RFP and any contract awarded pursuant to it. If the signatory is not the Respondent (if an individual) or the Respondent's company *President* or *Chief Executive Officer*, this document must attach evidence showing the individual's authority to bind the Respondent.

DO NOT SIGN THIS DOCUMENT IF YOU ARE NOT LEGALLY AUTHORIZED TO BIND THE RESPONDENT

SIGNATURE: _____

PRINTED NAME & TITLE: _____

DATE: _____

RESPONDENT LEGAL ENTITY NAME: _____

TECHNICAL RESPONSE & EVALUATION GUIDE

SECTION A: MANDATORY REQUIREMENTS. The Respondent must address all items detailed below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the response page number for each item in the appropriate space below.

The Solicitation Coordinator will review the response to determine if the Mandatory Requirement Items are addressed as required and mark each with pass or fail. For each item that is not addressed as required, the Proposal Evaluation Team must review the response and attach a written determination. In addition to the Mandatory Requirement Items, the Solicitation Coordinator will review each response for compliance with all RFP requirements.

RESPONDENT LEGAL ENTITY NAME:			
Response Page # (Respondent completes)	**Item Ref.**	**Section A— Mandatory Requirement Items**	**Pass/Fail**
		The Response must be delivered to the State no later than the Response Deadline specified in the RFP Section 2, Schedule of Events.	
		The Technical Response and the Cost Proposal documentation must be packaged separately as required (refer to RFP Section 3.2., *et. seq.*).	
		The Technical Response must NOT contain cost or pricing information of any type.	
		The Technical Response must NOT contain any restrictions of the rights of the State or other qualification of the response.	
		A Respondent must NOT submit alternate responses (refer to RFP Section 3.3.).	
		A Respondent must NOT submit multiple responses in different forms (as a prime and a subcontractor) (refer to RFP Section 3.3.).	
	A.1.	Provide the Statement of Certifications and Assurances (RFP Attachment 6.1.) completed and signed by an individual empowered to bind the Respondent to the provisions of this RFP and any resulting contract. The document must be signed without exception or qualification.	
	A.2.	Provide a statement, based upon reasonable inquiry, of whether the Respondent or any individual who shall cause to deliver goods or perform services under the contract has a possible conflict of interest (*e.g.*, employment by the State of Tennessee) and, if so, the nature of that conflict. NOTE: Any questions of conflict of interest shall be solely within the discretion of the State, and the State reserves the right to cancel any award.	
	A.3.	Provide a current bank reference indicating that the Respondent's business relationship with the financial institution is in positive standing. Such reference must be written in the form of a standard business letter, signed, and dated within the past three (3) months.	
	A.4.	Provide two current positive credit references from vendors with which the Respondent has done business written in the form of standard business letters, signed, and dated within the past three (3) months.	

RESPONDENT LEGAL ENTITY NAME:			
Response Page # (Respondent completes)	**Item Ref.**	**Section A— Mandatory Requirement Items**	**Pass/Fail**
	A.5.	Provide **EITHER**: (a) Provide an official document or letter from an accredited credit bureau, verified and dated within the last three (3) months and indicating a satisfactory credit score for the Respondent (NOTE: A credit bureau report number without the full report is insufficient and will not be considered responsive.) **OR** (b) Provide a current credit rating from Moody's, Standard & Poor's, Dun & Bradstreet, A.M. Best or Fitch Ratings, verified and dated within the last three (3) months and indicating a positive credit rating for the Respondent.	
	A.6.	Provide the Respondent's most recent independent audited financial statements. Said independent audited financial statements must: (a) reflect an audit period for a fiscal year ended within the last 36 months (b) be prepared with all monetary amounts detailed in United States currency; (c) be prepared under United States Generally Accepted Accounting Principles (US GAAP); (d) include: the auditor's opinion letter; financial statements; and the notes to the financial statements; and (e) be deemed, in the sole discretion of the State to reflect sufficient financial stability to undertake the subject contract with the State if awarded pursuant to this RFP. NOTES: ▪ Reviewed or Compiled Financial Statements will not be deemed responsive to this requirement and will not be accepted. ▪ All persons, agencies, firms, or other entities that provide opinions regarding the Respondent's financial status must be properly licensed to render such opinions. The State may require the Respondent to submit proof of such licensure detailing the state of licensure and licensure number for each person or entity that renders the opinions.	
	A.7.	Submit a written statement indicating that the claims processing and member services units offered as part of this proposal meet the following minimum qualifications: (a) as of the proposal date, the Respondent has been under contract for at least two (2) years to provide services similar to that offered in this proposal to one or more groups of at least ten thousand (10,000) members; (b) the Respondent has adjudicated medical claims for calendar year 2019 in excess of one hundred million dollars ($100,000,000).	
	A.8.	Provide the name of three (3) clients with a minimum of twenty-five thousand (25,000) members and with which the Respondent has contracted to provide medical claims administration services for a period of at least two (2) years as of the proposal date.	
	A.9.	Provide written confirmation that the Respondent has complied with all State insurance department filings. Provide a copy of the current license for	

RESPONDENT LEGAL ENTITY NAME:			
Response Page # (Respondent completes)	**Item Ref.**	**Section A— Mandatory Requirement Items**	**Pass/Fail**
		Third Party Administrator (TPA) of Life and/or Health Insurance from the Tennessee Department of Commerce and Insurance.	
	A.10.	Provide written confirmation that this proposal is offered with NO minimum participation requirements (*i.e.*, a minimum percentage or number of eligible Members enrolled), and that the Respondent understands that any resulting contract will NOT include such requirements. NOTE: The State shall NOT guarantee that a certain percentage or number of potential Members will enroll with a Contractor.	
	A.11.	Provide written confirmation that the Respondent will obtain National Committee for Quality Assurance (NCQA) Health Plan Accreditation at a level of 4 or 5 stars on or before December 31, 2022 (or a later date as specified by the State) and shall maintain it thereafter, as referenced in Contract Section A.6.n.	
	A.12.	Provide documentation that demonstrates the Respondent has already executed provider agreements for the proposed efficient and broad provider network(s) in all ninety-five (95) Tennessee counties for this contract and that the network currently meets ALL of the benchmarks outlined in Pro Forma Contract Attachment B Performance Guarantee #11 and #12 for a minimum of eighty percent (80%) of potential Members. The State will accept a detailed written attestation as an exception to any access standard deficiency that is due solely to a lack of available licensed providers or facilities for which to contract in a specific regional area(s).	
	A.13.	Submit a written confirmation that **ALL** examples and illustrations that the Respondent includes in its Technical Proposal constitute an offer to provide the same such service or product in Tennessee for the administrative fees that the Respondent bids in its Cost Proposal **UNLESS** the Respondent prominently explicitly states in bolded, capital letters beside each separate, excepted example that "**THIS SPECIFIC EXAMPLE IS FOR ILLUSTRATION PURPOSES ONLY AND WILL NOT BE PROVIDED TO THE STATE UNDER THIS CONTRACT FOR THE ALL-INCLUSIVE ADMINISTRATIVE FEES BID IN THIS RFP.**"	
	A.14.	Provide a written attestation that if awarded the contract the Respondent shall not use information gained through this Contract, including but not limited to utilization and pricing information, in marketing or expanding non-State business relationships or for any pecuniary gain.	
State Use – Solicitation Coordinator Signature, Printed Name & Date:			

TECHNICAL RESPONSE & EVALUATION GUIDE

SECTION B: GENERAL QUALIFICATIONS & EXPERIENCE. The Respondent must address all items detailed below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the response page number for each item in the appropriate space below. Proposal Evaluation Team members will independently evaluate and assign one score for all responses to Section B— General Qualifications & Experience Items.

RESPONDENT LEGAL ENTITY NAME:		
Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
	B.1.	Detail the name, e-mail address, mailing address, telephone number, and facsimile number of the person the State should contact regarding the response.
	B.2.	Describe the Respondent's form of business (*i.e*., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and business location (physical location or domicile).
	B.3.	Detail the number of years the Respondent has been in business.
	B.4.	Briefly describe how long the Respondent has been providing the goods or services required by this RFP.
	B.5.	Describe the Respondent's number of employees, client base, and location of offices.
	B.6.	Provide a statement of whether there have been any mergers, acquisitions, or change of control of the Respondent within the last ten (10) years. If so, include an explanation providing relevant details.
	B.7.	Provide a statement of whether the Respondent or, to the Respondent's knowledge, any of the Respondent's employees, agents, independent contractors, or subcontractors, involved in the delivery of goods or performance of services on a contract pursuant to this RFP, have been convicted of, pled guilty to, or pled *nolo contendere* to any felony. If so, include an explanation providing relevant details.
	B.8.	Provide a statement of whether, in the last ten (10) years, the Respondent has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, include an explanation providing relevant details.
	B.9.	Provide a statement of whether there is any material, pending litigation against the Respondent that the Respondent should reasonably believe could adversely affect its ability to meet contract requirements pursuant to this RFP or is likely to have a material adverse effect on the Respondent's financial condition. If such exists, list each separately, explain the relevant details, and attach the opinion of counsel addressing whether and to what extent it would impair the Respondent's performance in a contract pursuant to this RFP. NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Respondent must be properly licensed to render such opinions. The State may require the Respondent to submit proof of license for each person or entity that renders such opinions.
	B.10.	Provide a statement of whether there are any pending or in progress Securities Exchange Commission investigations involving the Respondent. If such exists, list each separately, explain the relevant details, and attach the opinion of counsel addressing whether and to what extent it will impair the Respondent's performance in a contract pursuant to this RFP.

RFP ATTACHMENT 6.2. — SECTION B (continued)

RESPONDENT LEGAL ENTITY NAME:		
Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
		NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Respondent must be properly licensed to render such opinions. The State may require the Respondent to submit proof of license for each person or entity that renders such opinions.
	B.11.	Provide a brief, descriptive statement detailing evidence of the Respondent's ability to deliver the goods or services sought under this RFP (*e.g.*, prior experience, training, certifications, resources, program and quality management systems, *etc.*).
	B.12.	Provide a statement of whether the Respondent intends to use subcontractors to meet the Respondent's requirements of any contract awarded pursuant to this RFP, and if so, detail: (a) the names of the subcontractors along with the contact person, mailing address, telephone number, and e-mail address for each; (b) a description of the scope and portions of the goods each subcontractor involved in the delivery of goods or performance of the services each subcontractor will perform; <u>and</u> (c) a statement specifying that each proposed subcontractor has expressly assented to being proposed as a subcontractor in the Respondent's response to this RFP.
	B.13.	Provide documentation of the Respondent's commitment to diversity as represented by the following: (a) <u>Business Strategy</u>. Provide a description of the Respondent's existing programs and procedures designed to encourage and foster commerce with business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises. Please also include a list of the Respondent's certifications as a diversity business, if applicable. (b) <u>Business Relationships</u>. Provide a listing of the Respondent's current contracts with business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises. Please include the following information: (i) contract description; (ii) contractor name and ownership characteristics (*i.e.*, ethnicity, gender, service-disabled veteran-owned or persons with disabilities); (iii) contractor contact name and telephone number. (c) <u>Estimated Participation</u>. Provide an estimated level of participation by business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities and small business enterprises if a contract is awarded to the Respondent pursuant to this RFP. Please include the following information: (i) a percentage (%) indicating the participation estimate. (Express the estimated participation number as a percentage of the total estimated contract value that will be dedicated to business with subcontractors and supply contractors having such ownership characteristics only and **DO <u>NOT</u> INCLUDE DOLLAR AMOUNTS**); (ii) anticipated goods or services contract descriptions; (iii) names and ownership characteristics (i.e., ethnicity, gender, service-disabled veterans, or disability) of anticipated subcontractors and supply contractors. NOTE: In order to claim status as a Diversity Business Enterprise under this contract, businesses must be certified by the Governor's Office of Diversity Business Enterprise (Go-DBE). Please visit the Go-DBE website at https://tn.diversitysoftware.com/FrontEnd/StartCertification.asp?TN=tn&XID=9810 for more information. (d) <u>Workforce</u>. Provide the percentage of the Respondent's total current employees by ethnicity and gender.

RFP ATTACHMENT 6.2. — SECTION B (continued)

RESPONDENT LEGAL ENTITY NAME:		
Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
		NOTE: Respondents that demonstrate a commitment to diversity will advance State efforts to expand opportunity to do business with the State as contractors and subcontractors. Response evaluations will recognize the positive qualifications and experience of a Respondent that does business with enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises and who offer a diverse workforce.
	B.14.	Provide a statement of whether or not the Respondent has any current contracts with the State of Tennessee or has completed any contracts with the State of Tennessee within the previous five (5) year period. If so, provide the following information for all of the current and completed contracts: (a) the name, title, telephone number and e-mail address of the State contact knowledgeable about the contract; (b) the procuring State agency name; (c) a brief description of the contract's scope of services; (d) the contract period; and (e) the contract number.
	B.15.	Provide customer references from individuals who are <u>not</u> current or former State employees for projects similar to the goods or services sought under this RFP and which represent: ▪ two (2) accounts Respondent currently services that are similar in size to the State; <u>and</u> ▪ three (3) completed projects. References from at least three (3) different individuals are required to satisfy the requirements above, e.g., an individual may provide a reference about a completed project and another reference about a currently serviced account. The standard reference questionnaire, which <u>must</u> be used and completed, is provided at RFP Attachment 6.4. References that are not completed as required may be deemed non-responsive and may not be considered. The Respondent will be <u>solely</u> responsible for obtaining fully completed reference questionnaires and ensuring they are e-mailed to the solicitation coordinator or including them in the sealed Technical Response. In order to obtain and submit the completed reference questionnaires follow one of the two processes below. Written: (a) Add the Respondent's name to the standard reference questionnaire at RFP Attachment 6.4. and make a copy for each reference. (b) Send a reference questionnaire and new, standard #10 envelope to each reference. (c) Instruct the reference to: (i) complete the reference questionnaire; (ii) sign and date the completed reference questionnaire; (iii) seal the completed, signed, and dated reference questionnaire within the envelope provided; (iv) sign his or her name in ink across the sealed portion of the envelope; and (v) return the sealed envelope directly to the Respondent (the Respondent may wish to give each reference a deadline, such that the Respondent will be able to collect all required references in time to include them within the sealed Technical Response). (d) <u>Do NOT open the sealed references upon receipt.</u> (e) Enclose all sealed reference envelopes within a larger, labeled envelope for inclusion in the Technical Response as required. E-mail:

RFP ATTACHMENT 6.2. — SECTION B (continued)

RESPONDENT LEGAL ENTITY NAME:		
Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
		(a) Add the Respondent's name to the standard reference questionnaire at RFP Attachment 6.4. and make a copy for each reference. (b) E-mail the reference with a copy of the standard reference questionnaire. (c) Instruct the reference to: (i) complete the reference questionnaire; (ii) sign and date the completed reference questionnaire; (iii) E-mail the reference directly to the Solicitation Coordinator by the RFQ Technical Response Deadline with the Subject line of the e-mail as "[Respondent Name] Reference for RFP 31786-00148. NOTES: ▪ The State will not accept late references or references submitted by any means other than the two which are described above, and each reference questionnaire submitted must be completed as required. ▪ The State will not review more than the number of required references indicated above. ▪ While the State will base its reference check on the contents of the reference e-mails or sealed reference envelopes included in the Technical Response package, the State reserves the right to confirm and clarify information detailed in the completed reference questionnaires, and may consider clarification responses in the evaluation of references. ▪ The State is under no obligation to clarify any reference information.
	B.16.	Provide a statement and any relevant details addressing whether the Respondent is any of the following: (a) is presently debarred, suspended, proposed for debarment, or voluntarily excluded from covered transactions by any federal or state department or agency; (b) has within the past three (3) years, been convicted of, or had a civil judgment rendered against the contracting party from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (c) is presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed above; and (d) has within a three (3) year period preceding the contract had one or more public transactions (federal, state, or local) terminated for cause or default.
	B.17.	For each of calendar years 2018 and 2019 provide the average number of members and annual claims volume for the top three largest accounts for which you have provided medical claims administration services. Identify the type of account (e.g., commercial, Medicare, or Medicaid). For each of the three accounts provide the performance guarantees and your compliance rate, including paid penalties, for the most recent plan year.
	B.18.	Provide a statement of whether, within the past five (5) years, either the Respondent or the Respondent's parent organization, affiliates, and subsidiaries (if any) has had a contract to provide medical claims administration services terminated prior to the contract end date or not re-contracted as a result of service/performance issues. If so, include an explanation of all relevant details including any corrective action taken by the Respondent to address the issues.
SCORE *(for all Section B—Qualifications & Experience Items above)*: *(maximum possible score = 5)*		

RFP ATTACHMENT 6.2. — SECTION B (continued)

RESPONDENT LEGAL ENTITY NAME:		
Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
State Use – Evaluator Identification:		

TECHNICAL RESPONSE & EVALUATION GUIDE

SECTION C: TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH. The Respondent must address all items (below) and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the response page number for each item in the appropriate space below.

A Proposal Evaluation Team, made up of three or more State employees, will independently evaluate and score the response to each item. Each evaluator will use the following whole number, raw point scale for scoring each item:

0 = little value ***1 = poor*** ***2 = fair*** ***3 = satisfactory*** ***4 = good*** ***5 = excellent***

The Solicitation Coordinator will multiply the Item Score by the associated Evaluation Factor (indicating the relative emphasis of the item in the overall evaluation). The resulting product will be the item's Raw Weighted Score for purposes of calculating the section score as indicated.

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
Implementation (Contract Section A.3) The Contractor is expected to assume all responsibilities described in the Pro Forma Contract (RFP Attachment 6.6). The State expects that all implementation tasks be performed and reviewed for completion during the implementation period. This applies to a new Contractor or the incumbent Contractor.					
	C.1	Provide a detailed project implementation plan (as an exhibit) demonstrating the tasks and timeline required to achieve completion and confirming your ability to assume all responsibilities as described in the Pro Forma contract by Go-Live.		3	
	C.2	Provide a roster of the proposed implementation team members detailing each member's primary work location, implementation role, responsibilities, and estimated number of hours per week during implementation.		2	
	C.3	Provide details about the major implementation tasks, their owners, any potential implementation risks or issues, and your plan to mitigate such risks or issues.		5	
Managing Cost Trend The State has maintained a year over year medical cost trend of 2.0%, 1.9% and 5.9% statewide over the past three years (2016-2019).					
	C.4.	Provide your year over year medical cost trend for the past two years for your fully insured book of business utilizing your proposed efficient provider network referenced in Section D Part 2.		8	
	C.5	Provide the year over year medical cost trend for the past two (2) years for three (3) of your largest self-funded employer clients utilizing your proposed efficient provider network referenced in Section D Part 2.		8	
	C.6	Provide an example of your most recently identified and mitigated troubling cost trend and the effective action(s) you took to get said cost trend under control. Include relevant data that demonstrates the resulting mitigation.		5	
	C.7	Provide a bulleted list of the cost-containment programs you would utilize for this account.		5	

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
Improving Quality of Care The State thinks quality of care is important for Member safety and to mitigate unnecessary medical costs. We monitor our plan's HEDIS measures, track leapfrog hospital quality results, and review choosing wisely guidelines.					
	C.8	Explain the tools you utilize, or have developed, to differentiate facility and provider quality beyond standard credentialing, how those differentiators are publicized to members, and how they are used to shift members to high quality providers.		8	
	C.9	Explain the data, information, or other supports you utilize to educate providers and assist in their efforts to manage care, improve care quality, and improve clinical outcomes.		5	
	C.10	Briefly describe a scenario where you worked with another large self-funded employer to improve the quality of care provided to their members?		8	
	C.11	Confirm your experience in improving health plan quality indicators, including HEDIS measures, CAHPS measures, provider satisfaction surveys, etc., and how you will apply that experience on this account.		5	
	C.12	Describe your ability to educate consumers on unneeded tests and procedures. Do you contract with any third parties for this service and if so, who?		5	
Value Based Initiatives (Contract Section A.10) Over the past four years the State has implemented eleven episodes of care in partnership with our current carriers. The State has also enhanced Member benefits to incentivize the utilization of transplant centers of excellence and enhanced Member benefits for orthopedic bundles with select providers. Both carriers offer online diabetes prevention programs for which the State has applied a no Member cost share benefit. **Do not include primary care or accountable care organization initiatives.**					
	C.13	Provide a list and high-level brief description of all initiatives or innovations in the Tennessee market that your company is currently engaged in that promotes value-based care versus fee-for-service within your proposed network.		10	
	C.14	Briefly describe your recommended incentives to encourage member or provider participation in your value-based initiatives. Note: DO NOT list any costs in your description.		8	
	C.15	Provide a list of the quality measures utilized to demonstrate value.		8	
	C.16	Briefly describe your direct provider engagement activities associated with value-based initiatives including education and any negative implications for poor quality and/or poor cost control.		8	
	C.17	Provide statistical details regarding the success of these initiatives (including savings) and their scale (percentage of claims and providers).		8	
	C.18	In 2019 what percent of your total dollars (claims, fees, and incentives) were paid to providers through value-oriented contracts (e.g., shared risk, bundled payment, capitation)?		5	

RESPONDENT LEGAL ENTITY NAME:	

Response Page # (Respondent completes)	Item Ref.	Section C— Technical Qualifications, Experience & Approach Items	Item Score	Evaluation Factor	Raw Weighted Score
Clinical Care Transformation (Contract Section A.10) Primary care integration and accountable care organizations have been in the market for a few years. Our Members currently have access to our carrier designed care transformation programs however, they are not currently required nor incentivized to participate.					
	C.19	Briefly summarize your approach to clinical care transformation.		5	
	C.20	Explain how your clinical care transformation approach encourages providers to focus on the entire patient care journey including chronic condition management, episodic condition management, mitigation of social determinants of health, transition of care post hospitalization, reducing and redirecting care to the most appropriate settings, and integrating behavioral health.		10	
	C.21	Provide a list of the quality measures utilized to demonstrate value.		8	
	C.22	Briefly describe your direct provider engagement activities including education and any implications for poor quality and/or poor cost control.		5	
	C.23	Provide the details regarding the success of your clinical care transformation approach (including savings) and their scale (percentage of claims and providers).		8	
	C.24	Briefly describe the integration and measurement of behavioral health care in your clinical care transformation approach. Include any current NCQA (Behavioral Health Integration) or URAC (Measurement Based Care) distinctions, or similar, or plans to obtain such distinctions, or similar, in the next plan year.		7	
	C.25	What percent of your plan participants are attributed to a provider participating in a delivery reform program (e.g., an ACO, PCMH or other delivery model) in which patients are attributed to a provider?		5	
Expert Medical Opinion (Contract Section A.9.q) At the State's request, the Contractor shall provide expert medical opinion services for our Members facing a new serious diagnosis, encountering difficulty seeking a diagnosis, and/or continuing to manage a complex diagnosis with difficulty.					
	C.26	Confirm your ability to provide our members with expert medical opinion services. Do you contract with a third party for these services and if so, who?		**10**	
	C.27	Are medical records gathered and compiled on behalf of the member and if so, what is the expected timeframe from member request to completion?		**5**	
	C.28	Does the member have the opportunity for a virtual or in person consultation with the expert medical opinion reviewer and is a full written report provided?		**5**	
	C.29	Does the service include an assigned member care coordinator to assist the member throughout the process including provider referrals, appointment scheduling, and any needed medical care coordination?		**5**	
	C.30	Confirm a member's ability to engage in expert medical opinion services via call center, website, and mobile application.		**3**	

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
	C.31	Confirm your ability to implement an enhanced benefit design for member's utilizing expert medical opinion services such as a cost share reduction or waiver.		**3**	
Utilization Management (Contract Section A.9.) The Contractor shall provide the utilization management services required in the Pro Forma Contract including utilization management of high cost services, services utilized to treat complex conditions, lengthy facility-based care, etc.					
	C.32	Identify any third parties used to carry out the following services: utilization management, prior approval, predeterminations, precertification and/or prior notification of inpatient and outpatient services.		3	
	C.33	Confirm public accessibility of your medical policies on your website for both members and providers?		5	
	C.34	Briefly describe how your medical policies are developed and applied in processing claims?		5	
	C.35	Briefly describe your management, oversight, and your adherence to your published medical necessity coverage policies.		8	
	C.36	What criteria are used for determining services considered experimental and investigational?		3	
	C.37	List and briefly describe all case management services and the associated conditions available to our Members including but not limited to cancer, cardiac surgeries, maternity, severe injury/trauma, neonate admissions, cognitive or physical disability, dialysis, and transplants.		10	
	C.38	Briefly describe your experience working with multiple carved out vendors for the same client to improve member care coordination throughout all levels of care.		5	
Member Services and Member Navigation/Advocacy (Contract Section A.7.) The State requires the Contractor to provide Member services and Member navigation services to assist Members with resources and services, including but not limited to, claim and bill resolution, maximizing available benefits, navigating appeals, finding high quality care, and closing gaps in care.					
	C.39	Briefly summarize the experience and qualifications of the dedicated member services staff.		3	
	C.40	Briefly describe how dedicated member service representatives and advocates will be trained on this account prior to annual enrollment and ongoing account training.		5	
	C.41	Briefly describe how a member services representative or advocate would handle a member who is experiencing a balance billing issue for an out-of-network emergency room visit.		8	
	C.42	Briefly describe how a member services representative or advocate would handle a member who is having difficulty finding a specialist who can treat their condition, is accepting new patients, and has appointment availability within the next two weeks.		5	
	C.43	Briefly describe how a member services representative or advocate would handle a member who is angry about a denied appeal.		8	

RESPONDENT LEGAL ENTITY NAME:	

Response Page # (Respondent completes)	Item Ref.	Section C— Technical Qualifications, Experience & Approach Items	Item Score	Evaluation Factor	Raw Weighted Score
	C.44	Briefly describe your ability to provide members with the navigation services described above and in the Pro Forma Contract.		10	
Member Call Center (Contract Section A.11.) Describe the following characteristics of the Member services unit/call center. If there are multiple facilities or groups serving the account, please answer each question for each facility and/or group.					
	C.45	Location and hours of operation of the call center, including a back-up call center for operational readiness in the event of a natural disaster, etc.		2	
	C.46	The flexibility of the call center to handle fluctuations in call volume, its scalability, and the proportion of its capacity currently in use.		2	
	C.47	Confirm your ability to record and index all calls for retrieval to review potential member or member services representative issues.		2	
	C.48	Briefly describe the investments that your organization/company has made in call center technology over the past three (3) years that have enhanced customer service and member satisfaction.		2	
	C.49	Provide the number of dedicated member services representatives that will be assigned to this account.		5	
Member Appeals (Contract Section A.8.) The State requires the Contractor to provide Members with two internal and one independent review appeals. 100% of expedited appeals for urgent care shall be decided within 72 hours, 95% of non-urgent preservice appeals shall be decided within 30 days and 95% non-urgent post service appeals within 60 days.					
	C.50	Confirm your ability to provide members with two internal appeals and at least one independent review appeal, not including peer to peer and provider appeals.		5	
	C.51	Provide your 2019 appeal processing outcomes for your Tennessee fully insured book of business. Appeals: CY 2019 Expedited within 72 hours: % Preservice within 30 days: % Post service within 60 days: %		5	
Member Communications/Materials (Contract Section A.13. and A.14.) The State expects the Contractor to provide a fresh perspective with respect to marketing materials and Member engagement in addition to the minimum Member communications materials.					
	C.52	Confirm your ability to provide an annual written marketing and communications plan for ongoing member education.		5	
	C.53	Briefly describe any new or innovative marketing or communication approaches to member education that easily describe complex health care issues to members with low health literacy and the average health care consumer.		5	
	C.54	Briefly describe your strategy around using social media and other new technologies to communicate health benefits to members.		3	
	C.55	Confirm your ability to create and provide all member materials including but not limited to member handbooks, welcome kits, ID Cards, etc. according to contract standards.		3	

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
Splash Page, Website, and Mobile Application (Contract Section A.15.) The State thinks Member education and navigation are critical with respect to online web-based resources including information regarding quality healthcare, quality providers, and cost transparency.					
	C.56	Confirm your ability to support State members with a custom splash page containing benefits, plan information, forms and materials that is available to prospective enrollees as well as enrolled members without a login/password.		5	
	C.57	Briefly describe the current web-based capabilities available to members. Include a list of services and identify those that are also mobile enabled or available through your mobile application. Include screen shots (no more than 5) that detail the primary website capabilities available for members and a copy of your site map(s). For any capabilities that are not in current operation, submit draft materials.		5	
	C.58	Briefly describe your available consumer cost transparency and quality tools. Include the sources of data presented to members, and how frequently data is updated. Provide screen shots (no more than 5) representing the different types of cost and quality data contained in these tools. If you have changes or updates planned to your tools, please briefly describe those anticipated changes and the timing for such changes.		8	
	C.59	Provide a video demonstration of a typical member experience conducting the following cost and quality searches on your online tools for the following: i. a sore throat primary care visit; ii. a diagnostic lumbar magnetic resonance imaging (MRI); iii. outpatient knee arthroscopy; and iv. inpatient hysterectomy. For this demonstration, assume the searches are for treatment for an adult member at an in-network provider or facility. Include how a member would select a high-quality low-cost provider at a high-quality low-cost facility and their expected costs including a breakdown of copay, deductible, and coinsurance for all provider, facility, and ancillary services associated with the expected visit.		10	
Staffing (Contract Section A.5.) The Contractor's account management team is important for the long-term success and working relationship during the contract term. Dedicated resources ensure adequate support of a large complex contract.					
	C.60	Identify the designated account management team you propose to work on this account (pending State approval). Provide an organization chart, including names and titles, of management and key personnel that will be responsible for account management including the estimated number of hours per week. Indicate whether the person who will fill each position is already employed by your firm or whether he/she will be recruited upon Contract award. If the person(s) are already employed, provide a brief resume to include their title, role, work history, education (if applicable), and length of time with your		5	

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		company. At a minimum, the positions should include: v. Account Executive (Dedicated) – Responsible for overall account relationship including strategic planning in relation to plan performance, consultative services, recommendations for benefit design and cost containment opportunities, and overseeing contractual services. vi. Account Manager (Dedicated) – Responsible for providing daily operational support, member support, as well as strategic planning and analysis. vii. Operations Manager – Responsible for all benefits set up and claims operations. viii. Enrollment Analyst – Responsible for all 834 file loads and enrollment corrections/updates. ix. Reporting Analyst – Responsible for all reporting including Ad-Hoc requests. x. Medical/Clinical Program Director – Responsible for all UM, Case Management, and other clinical support. xi. Member Services Manager – Responsible for all call center and customer service functions.			
	C.61	Detail the level of decision-making authority available to the Account Team to resolve issues of importance to the State.		8	
	C.62	Define how the Account Team will be responsive, creative, and innovative in developing solutions and recommendations to reduce healthcare cost, improve quality of healthcare, improve access to healthcare, and increase Member satisfaction.		5	
Claims Processing, Payment and Reconciliation (Contract Section A.12.)					
	C.63	Confirm your ability to accurately process, pay, and reconcile claims in accordance with the Pro Forma Contract requirements and Plan Documents.		8	
	C.64	Confirm your ability to coordinate accurate sharing of benefit accumulator claims data with other State contractors to allow accurate claims processing.		5	
	C.65	Describe the initial and ongoing testing and auditing of the claims system for accuracy, timeliness, and quality.		3	
	C.66	When errors are found, what is the time frame for correction of the claim?		3	
	C.67	Confirm your ability to ensure that the State will receive one hundred percent (100%) of all rebates, including pharmacy, obtained on behalf of the State, by the Contractor (including rebate aggregators or any similar contracted entities).		8	
	C.68	Confirm your ability to ensure that the State only pays for the negotiated provider payment terms and no payment differential is retained by the Contractor, including bill negotiation services, recoveries,		5	

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		overpayments, etc. except as expressly stated in C.3.			
Data Integration (Contract Section A.22.) and Information Systems (Contract Section A.23.)					
	C.69	Confirm that your enrollment file team has read and reviewed the State's 834 Companion Guide and confirm your ability to process the State's full standard 834 enrollment file including the quality control processes that will be used to ensure the timely, accurate and complete update of enrollment files as well as how enrollment errors will be resolved and communicated to the State.		8	
	C.70	Briefly describe any modifications to existing hardware and software that will be required to meet the requirements of the Pro Forma contract and the timeframe to make any needed modifications.		3	
	C.71	Confirm your ability to share claims data files with all State contractors (including but not limited to PBM, EAP/BHO, DSS, etc.) as required for data integration, member accumulation tracking, and member care coordination.		5	
	C.72	Confirm your ability to meet the Pro Forma contract System and Information Security and Access Management Requirements.		3	
Reporting and Systems Access (Contract Section A.21.)					
	C.73	Confirm your ability to provide all reports and data in the format, in the level of detail, and on the timelines required in the Pro Forma contract.		5	
	C.74	Briefly describe the process by which State staff can add new members to the eligibility system and how soon, after an addition, claims can be adjudicated for the member.		5	
	C.75	Detail the extent to which authorized State staff will have access to the Respondent's system(s) for the purpose of creating and generating ad-hoc reports.		5	
	C.76	Confirm the State's access to a designated reporting analyst to provide all contract reports as well as ad-hoc reports on an as requested basis, especially during legislative session.		5	
Fraud and Abuse (Contract Section A.20.)					
	C.77	Confirm your ability to implement procedures for preventing and detecting fraud and abuse as described in the Pro Forma contract.		3	
	C.78	Briefly describe the claim system processes and edits in place to identify improper provider billing. Specifically address up-coding, unbundling of services, and duplicate bill submissions.		5	
	C.79	Please briefly describe your ability to perform hospital claim reviews for payments greater than $100,000 including but not limited to, appropriate level of care coding and billing for miscellaneous items already included in the DRG.		8	
	C.80	How do you detect claims fraud? Are your adjudicators trained to identify potentially fraudulent claim expenses and claiming patterns?		5	

RFP ATTACHMENT 6.2. — SECTION C (continued)

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
Privacy & Confidentiality					
	C.81	Describe the safeguards to protect the privacy and confidentiality of Members and to prevent unauthorized use or disclosure of Protected Health Information (PHI) that you create, receive, transmit, or maintain. Complete Appendix 7.11 regarding HIPAA Business Associate Assessment and submit it with your technical response as a separate appendix/exhibit file. **DO NOT** modify any of the questions asked in the appendix.		5	
The Solicitation Coordinator will use this sum and the formula below to calculate the section score. All calculations will use and result in numbers rounded to two (2) places to the right of the decimal point.			**Total Raw Weighted Score:** *(sum of Raw Weighted Scores above)*		
Total Raw Weighted Score / **Maximum Possible Raw Weighted Score**			**X 35** *(maximum possible score)*	**= SCORE:**	
State Use – Evaluator Identification:					
State Use – Solicitation Coordinator Signature, Printed Name & Date:					

TECHNICAL PROPOSAL & EVALUATION GUIDE

NOTICE: Section D, Part 1 is applicable to the currently established **Efficient** statewide network option the Respondent elects to offer. The proposed network must meet access standards defined in Contract Attachment B in the pro forma contract.

Complete and address the Technical Proposal & Evaluation Guide – Section D.1 for the currently established Efficient statewide network

SECTION D, PART 1: NETWORK. The Respondent must address all items below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the proposal page number for each item in the appropriate space below.

A Proposal Evaluation Team, made up of three or more State employees, will independently evaluate and score the Respondent's response to items in Section D, Part 1. Each evaluator will use the following whole number, raw point scale for scoring each item:

0 = little value ***1 = poor*** ***2 = fair*** ***3 = satisfactory*** ***4 = good*** ***5 = excellent***

The Solicitation Coordinator will, then, multiply the Item Score by the associated Evaluation Factor (indicating the relative emphasis of the item in the overall evaluation). The resulting product will be the item's raw, weighted score for purposes of calculating the Section D, Part 1 score as indicated.

RESPONDENT LEGAL ENTITY NAME:					
Proposal Page # (Respondent completes)	**Item Ref.**	**Section D— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
Provider Network Management The State is seeking an Efficient network, as referenced in Section D Part 2, in both quality and cost. In addition to the Efficient network the State may decide to offer a Broad network, referenced in Section D Part 2, choice to Members at an additional premium cost. Answer the following questions only as they relate to your **Efficient** network.					
	D.1.1.	Define if all of your networks are managed by your company or if you subcontract any portion of your network from another organization. If you subcontract, please provide information about the subcontracted network.		**6**	
	D.1.2	Describe your network provider services including provider training, technical assistance, and how quality standards are communicated and enforced.		**6**	
	D.1.3	Describe your approach to provider network management to ensure your network maintains high quality high performing providers at a reasonable cost. Include your approach to involuntary termination as necessary.		**10**	
Provider Network Development The State is seeking an Efficient network in both quality and cost. In addition to the Efficient network the State may decide to offer a Broad network choice to Members at an additional premium cost. Answer the following questions only as they relate to your **Efficient** network.					
	D.1.4	Describe your approach to network development (including physician profiling and hospital profiling), maintenance (including the standard period of provider agreement renegotiation and renewal), and provider credentialing.		**6**	
	D.1.5.	Describe your approach to developing high performance or tiered networks and your plans to		**8**	

		expand or develop high performance networks in Tennessee.			
	D.1.6	Describe the quality measures and cost criteria used to identify high performing providers and how those providers are identified to encourage member utilization.		**10**	
Provider Network Turnover					
	D.1.7	Detail the voluntary and involuntary network provider turnover rate for the Efficient network in Tennessee, as referenced in Section D Part 2, you are proposing for this account (calculated as the number of provider agreements terminated divided by the total number of provider agreements at the start of that calendar year) for CY 2019 and CY 2020 for hospitals, PCPs, and specialists.		**4**	
National Provider Network					
	D.1.8.	Describe your currently established national network you are proposing to use for this contract, including the provider and facility participation that enrolled members will access if they live out of state or are traveling.		**5**	
	D.1.9	Describe any limitations regarding your national network including, but not limited to, less competitive pricing arrangements, utilization management/prior authorizations, provider quality management, member access, and level of claims data available.		**5**	

	CY 2019		CY2020	
	Vol.	InVol.	Vol.	InVol.
Hospitals				
PCPs				
Specialists				

The Solicitation Coordinator will use this sum and the formula below to calculate the section score. All calculations will use and result in numbers rounded to two (2) places to the right of the decimal point.	**Total Raw Weighted Score:** *(sum of Raw Weighted Scores above)*	
Total Raw Weighted Score **Maximum Possible Raw Weighted Score**	**X 5** *(maximum possible score)* **= SCORE:**	

State Use – Evaluator Identification:

State Use – Solicitation Coordinator Signature, Printed Name & Date:

TECHNICAL PROPOSAL & EVALUATION GUIDE

NOTICE: Section D, Part 2 is applicable to the currently established **Efficient and Broad** network options the Respondent elects to offer. All proposed networks must meet access standards defined in Contract Attachment B in the pro forma contract.

Complete and address the Technical Proposal & Evaluation Guide – Section D.2.1 through D.2.6 for the Efficient network option and D.2.7 through D.2.12 for the Broad network option.

SECTION D, PART 2: NETWORK. The Respondent must address all items below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the proposal page number for each item in the appropriate space below.

A Proposal Evaluation Team, made up of three or more State employees, will independently evaluate and score the Respondent's response to items in Section D, Part 2. Each evaluator will use the following whole number, raw point scale for scoring each item:

0 = little value ***1 = poor*** ***2 = fair*** ***3 = satisfactory*** ***4 = good*** ***5 = excellent***

The Solicitation Coordinator will calculate the raw scores as explained in the raw score calculation notes following the table below, and, then, multiply each raw score by the associated Evaluation Factor (indicating the relative emphasis of the item). The resulting product will be the item's raw, weighted score for purposes of calculating the Section D, Part 2 score as indicated.

RESPONDENT LEGAL ENTITY NAME:					
Name of currently established Proposed Efficient Network to be used for this contract					
Name of currently established Proposed Broad Network to be used for this contract					
Proposal Page # (Respondent completes)	**Item Ref.**	**Section D— Technical Qualifications, Experience & Approach Items**	**Item Raw Score**	**Evaluation Factor**	**Raw Weighted Score**
Provider Network Access Analysis. For the currently established proposed **Efficient** network to be used for this contract, coordinate with Quest and submit your **Network Access Analysis Report** for your participating Acute Care Hospitals, Primary Care Physicians, Pediatricians, Obstetricians/Gynecologists, Cardiologists and Endocrinologists **IN TENNESSEE ONLY**, as required in **Appendix 7.2,** as illustrated in **Appendix 7.4**. and using the State's total Tennessee participant population data provided in **Appendix 7.5, TN ZIP Code Counts.** **Note: Evaluators will use the Network Access Analysis Report to score the following categories based upon the proposed Efficient network as it compares to the Comparative Provider Network Access Analysis in Appendix 7.4.**					
	D.2.1	**Acute Care Hospitals**		**15**	
	D.2.2	**Primary Care Physicians**		**10**	
	D.2.3	**Pediatricians**		**10**	
	D.2.4	**Obstetricians/Gynecologists**		**10**	
	D.2.5	**Cardiologists**		**8**	
	D.2.6	**Endocrinologists**		**5**	

RFP ATTACHMENT 6.3. (continued)

Provider Network Access Analysis. For the currently established proposed **Broad** network to be used for this contract, coordinate with Quest and submit your **Network Access Analysis Report** for your participating Acute Care Hospitals, Primary Care Physicians, Pediatricians, Obstetricians/Gynecologists, Cardiologists and Endocrinologists **IN TENNESSEE ONLY**, as required in **Appendix 7.2** , as illustrated in **Appendix 7.4**. and using the State's total Tennessee participant population data provided in **Appendix 7.5, TN ZIP Code Counts.**

Note: Evaluators will use the Network Access Analysis Report to score the following categories based upon the proposed Broad network as it compares to the Comparative Provider Network Access Analysis in Appendix 7.4.

	D.2.7	**Acute Care Hospitals**		**5**	
	D.2.8	**Primary Care Physicians**		**4**	
	D.2.9	**Pediatricians**		**4**	
	D.2.10	**Obstetricians/Gynecologists**		**4**	
	D.2.11	**Cardiologists**		**3**	
	D.2.12	**Endocrinologists**		**2**	
The Solicitation Coordinator will use this sum and the formula below to calculate the section score. All calculations will use and result in numbers rounded to two (2) places to the right of the decimal point.			**Total Raw Weighted Score: (sum of Raw Weighted Scores above)**		
Total Raw Weighted Score / **Maximum Possible Raw Weighted Score**		**X 10 (maximum possible score)**	**= SCORE:**		

State Use – Evaluator Identification:

State Use – Solicitation Coordinator Signature, Printed Name & Date:

RFP ATTACHMENT 6.3. (continued)

TECHNICAL PROPOSAL & EVALUATION GUIDE

NOTICE: SECTION D, PART 3: Section D, Part 3 is applicable to the currently established Efficient network option the Respondent elects to offer. All proposed networks must meet access standards defined in Contract Attachment B in the pro forma contract.

NETWORK. The Respondent must address all items below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the proposal page number for each item in the appropriate space below.

Complete and address the Technical Proposal & Evaluation Guide – Section D.3 for the current Efficient network option you are proposing to use for this contract.

A Proposal Evaluation Team, made up of three or more State employees, will independently evaluate and score the Respondent's response to items in Section D, Part 3. Each evaluator will use the following whole number, raw point scale for scoring each item:

0 = little value ***1 = poor*** ***2 = fair*** ***3 = satisfactory*** ***4 = good*** ***5 = excellent***

The Solicitation Coordinator will calculate the raw scores as explained in the raw score calculation notes following the table below, and, then, multiply each raw score by the associated Evaluation Factor (indicating the relative emphasis of the item). The resulting product will be the item's raw, weighted score for purposes of calculating the Section D, Part 3 score as indicated.

RESPONDENT LEGAL ENTITY NAME:					
Proposal Page # (Respondent completes)	**Item Ref.**	**Section D— Technical Qualifications, Experience & Approach Items**	**Item Raw Score**	**Evaluation Factor**	**Raw Weighted Score**
	D.3.1	**Provider Disruption Analysis.** Using the provider listing in Appendix 7.3 and following the instructions on tab 1 (2019 Utilized Providers), indicate which providers are in the proposed network as of the proposal date. Summarize the information in Table 2. **Note: The State will provide the Respondent's information along with Incumbent information in Appendix 7.3 to the Evaluation team.**		**10**	
The Solicitation Coordinator will use this sum and the formula below to calculate the section score. All calculations will use and result in numbers rounded to two (2) places to the right of the decimal point.			**Total Raw Weighted Score:** *(sum of Raw Weighted Scores above)*		
Total Raw Weighted Score **Maximum Possible Raw Weighted Score**			**X 10** *(maximum possible score)*	**= SCORE:**	
State Use – Evaluator Identification:					
State Use – Solicitation Coordinator Signature, Printed Name & Date:					

COST PROPOSAL & SCORING GUIDE

The Respondent shall complete and submit its Cost Proposal in accordance with the instructions given in RFP Section 3.2.2.2. The Respondent will use an XLS spreadsheet to prepare the Cost Proposal. This spreadsheet is found at the following website address, under the section labeled RFP # 31786-00148:

https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/supplier-information/request-for-proposals--rfp--opportunities1.html

Further instructions specific to the content of the Cost Proposal are found in the above referenced spreadsheet.

The spreadsheet will calculate the Total Evaluation Cost Amount. This Amount will be used in the formula below to derive the Respondent's Cost Proposal score.

Lowest Evaluation Cost Amount from all Proposals / Evaluation Cost Amount Being Evaluated	**X 40** *(maximum section score)*	**= SCORE:**	
State Use – Solicitation Coordinator Signature, Printed Name & Date:			

REFERENCE QUESTIONNAIRE

The standard reference questionnaire provided on the following pages of this attachment MUST be completed by all individuals offering a reference for the Respondent.

The Respondent will be solely responsible for obtaining completed reference questionnaires as required (refer to RFP Attachment 6.2., Technical Response & Evaluation Guide, Section B, Item B.17.), and for enclosing the sealed reference envelopes within the Respondent's Technical Response.

RFP # 31786-00148 REFERENCE QUESTIONNAIRE

REFERENCE SUBJECT: RESPONDENT NAME (completed by Respondent before reference is requested)

The "reference subject" specified above, intends to submit a response to the State of Tennessee in response to the Request for Proposals (RFP) indicated. As a part of such response, the reference subject must include a number of completed and sealed reference questionnaires (using this form).

Each individual responding to this reference questionnaire is asked to follow these instructions:

- complete this questionnaire (either using the form provided or an exact duplicate of this document);

sign and date the completed questionnaire; and follow either process outlined below:

Physical

- seal the completed, signed, and dated questionnaire in a new standard #10 envelope;
- sign in ink across the sealed portion of the envelope; and
- return the sealed envelope containing the completed questionnaire directly to the reference subject.

E-Mail

- email the completed Questionnaire to the Solicitation Coordinator, Seannalyn Brandmeir, at Seannalyn.brandmeir@tn.gov.

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(1) What is the name of the individual, company, organization, or entity responding to this reference questionnaire?

(2) Please provide the following information about the individual completing this reference questionnaire on behalf of the above-named individual, company, organization, or entity.

NAME:	
TITLE:	
TELEPHONE #	
E-MAIL ADDRESS:	

(3) What goods or services does/did the reference subject provide to your company or organization?

(4) What is the level of your overall satisfaction with the reference subject as a vendor of the goods or services described above?

Please respond by circling the appropriate number on the scale below.

	1	**2**	**3**	**4**	**5**	
least satisfied						**most satisfied**

RFP # 31786-00148 REFERENCE QUESTIONNAIRE — PAGE 2

If you circled 3 or less above, what could the reference subject have done to improve that rating?

(5) If the goods or services that the reference subject provided to your company or organization are completed, were the goods or services provided in compliance with the terms of the contract, on time, and within budget? If not, please explain.

(6) If the reference subject is still providing goods or services to your company or organization, are these goods or services being provided in compliance with the terms of the contract, on time, and within budget? If not, please explain.

(7) How satisfied are you with the reference subject's ability to perform based on your expectations and according to the contractual arrangements?

(8) In what areas of goods or service delivery does/did the reference subject excel?

(9) In what areas of goods or service delivery does/did the reference subject fall short?

(10) What is the level of your satisfaction with the reference subject's project management structures, processes, and personnel?

Please respond by circling the appropriate number on the scale below.

	1	2	3	4	5	
least satisfied						**most satisfied**

What, if any, comments do you have regarding the score selected above?

RFP # 31786-00148 REFERENCE QUESTIONNAIRE — PAGE 3

(11) Considering the staff assigned by the reference subject to deliver the goods or services described in response to question 3 above, how satisfied are you with the technical abilities, professionalism, and interpersonal skills of the individuals assigned?

Please respond by circling the appropriate number on the scale below.

	1	2	3	4	5	
least satisfied						**most satisfied**

What, if any, comments do you have regarding the score selected above?

(12) Would you contract again with the reference subject for the same or similar goods or services?

Please respond by circling the appropriate number on the scale below.

	1	2	3	4	5	
least satisfied						**most satisfied**

What, if any, comments do you have regarding the score selected above?

REFERENCE SIGNATURE:
(by the individual completing this request for reference information)

_____
(must be the same as the signature across the envelope seal)

DATE: _____

RFP ATTACHMENT 6.5.

SCORE SUMMARY MATRIX

	RESPONDENT NAME		*RESPONDENT NAME*		*RESPONDENT NAME*	
GENERAL QUALIFICATIONS & EXPERIENCE (maximum: 5)						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE:		**AVERAGE:**		**AVERAGE:**	
TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH (maximum: 35)						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE:		**AVERAGE:**		**AVERAGE:**	
TECHNICAL QUALIFICATIONS, NETWORK ANALYSIS (maximum: 25)						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE:		**AVERAGE:**		**AVERAGE:**	
COST PROPOSAL (maximum: 40)	**SCORE:**		**SCORE:**		**SCORE:**	
TOTAL RESPONSE EVALUATION SCORE: (maximum: 100)						

Solicitation Coordinator Signature, Printed Name & Date:

RFP # 31786-00148 *PRO FORMA* CONTRACT

The *Pro Forma* Contract detailed in following pages of this exhibit contains some "blanks" (signified by descriptions in capital letters) that will be completed with appropriate information in the final contract resulting from the RFP.

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
STATE INSURANCE COMMITTEE,
LOCAL EDUCATION INSURANCE COMMITTEE,
AND LOCAL GOVERNMENT INSURANCE COMMITTEE
AND
CONTRACTOR NAME

This Contract, by and between the State of Tennessee, State Insurance Committee, Local Education Insurance Committee, and the Local Government Insurance Committee ("State") and Contractor Legal Entity Name ("Contractor"), is for the provision of medical third party administrative services, as further defined in the "SCOPE." State and Contractor may be referred to individually as a "Party" or collectively as the "Parties" to this Contract.

The Contractor is a/an Individual, For-Profit Corporation, Non-Profit Corporation, Special Purpose Corporation Or Association, Partnership, Joint Venture, Or Limited Liability Company.
Contractor Place of Incorporation or Organization: Location
Contractor Edison Registration ID # Number

A. SCOPE:

A.1. General

a. 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.

b. The Contractor shall serve all Members, both statewide and nationally, through their proposed Efficient Network and, at the State's request, shall also offer their Broad Network to Members.

c. The Contractor shall provide administrative services for Members of the State's Plans, who elect to enroll in one of the options offered by the State.

d. The State may adjust the premium that it charges Members to enroll with the Contractor in order to account for changes in the Contractor's provider payment terms and other factors as the State deems appropriate. Such adjustments may vary by TPA. Similarly, the State may elect to adjust the State contribution for State and higher education employees based on these and other factors. The State's decisions on these issues are final and not subject to appeal.

A.2. Definitions. For purposes of this Contract, definitions shall be as follows and as set forth in the Contract.

a. Account Executive: Dedicated full-time employee of the Contractor who has primary oversight and management of the Contract and all services, deliverables, and requirements within.

b. Account Manager: Dedicated full-time employee of the Contractor who supports the Contract primarily handling member services and issues including claims, benefits, and provider concerns.

c. Affiliate: A business organization or entity that, directly or indirectly, is owned or controlled by the Contractor, or owns or controls the Contractor, or is under common ownership or control with the Contractor.

d. Agency Benefits Coordinator ("ABC"): An Agency Benefits Coordinator serves as the liaison between the Plan and Members. There is at least one ABC in every employer agency/entity.

e. At-Risk Performance Payment: Contractor's payment based on KPI performance listed on the SLA Scorecard set forth in Contract Attachment D. The payment is calculated based on the SLA Scorecard quarterly score and percentage of the administrative fees at risk.

f. Average Sales Price ("ASP"): Equals the volume-weighted, per-unit average of manufacturer sales prices for each product that falls within a single HCPCS code. ASP is computed using actual sales revenues to a manufacturer, i.e., list price minus all price concessions (volume discounts, prompt pay discounts, cash discounts, free goods, chargebacks, rebates, etc.). Thus, ASP is not a list price like Wholesale Acquisition Cost (WAC). The ASP methodology uses quarterly drug pricing data submitted to CMS by drug manufacturers.

g. Average Speed of Answer ("ASA"): The average waiting time between (a) the moment at which a caller to the Contractor's call center first hears an introductory greeting and enters the queue and (b) the time at which a Member services representative at the call center answers the call. For this definition, the term "answer" shall mean begin an uninterrupted dialogue with the caller. If a member services representative asks the caller to hold during the first sixty (60) seconds of the dialogue, the Contractor shall not consider the call to be answered for purposes of this definition until the member services representative returns to the caller and begins an uninterrupted dialogue.

h. Balance Bill or Billing: Seeking payment from a Member for any charged amount(s) over and above the MAC or contract rates.

i. Benefits Administration ("BA"): The division of the Tennessee Department of Finance & Administration that administers the Plans.

j. Broad Network: The Contractor's most inclusive provider network containing the largest number of contracted providers and hospital facilities.

k. Business Days: Traditional workdays, including Monday, Tuesday, Wednesday, Thursday, and Friday. State Holidays are excluded.

l. Centers of Excellence: Providers who are selected to perform certain specialized procedures because of their expertise, outcomes and favorable financial arrangements.

m. CFR: Code of Federal Regulations.

n. Clean Claim: A claim received by the Contractor for adjudication, and which requires no further information, adjustment, or alteration by the provider in order to be processed and paid by the Contractor. In addition to the provider, this includes information, adjustment, or alteration by the Member, the subscriber, third-party payers (i.e. – Medicare), and/or plan sponsor.

o. Coinsurance: That percentage of the MAC for each medical or pharmaceutical service provided to a member that is the responsibility of the member.

p. Collaborative Physical/Behavioral Health Care: An approach to integration in which primary care providers, care managers, and behavioral health consultants work together to provide evidence-based collaborative care and monitor patients' progress.

q. Copayment: That portion of the MAC (flat dollar amount) for each medical or pharmaceutical service provided to a member that is the responsibility of the member.

r. Dedicated: Wholly assigned to the State and this contract without supporting additional clients or other non-State contracts.

s. Deductible: The amount that must be paid by each member prior to payment of covered benefits by the Contractor.

t. Denied Claim: A claim that is not paid for reasons such as eligibility and coverage rules.

u. Designated: Assigned to support this contract but may support additional clients or contracts.

v. Decision Support System ("DSS"): A database and query tool containing health care information and claims data which allows for analytics and executive decision making.

w. EAP/BHO: Employee Assistance Program/ Behavioral Health Organization

x. Edison: The State's enterprise resource planning system, which supports human resources, payroll, insurance, contracting, procurement and other agency functions.

y. Efficient Network: A provider network that limits the number of contracted providers and hospitals in order to offer best pricing and in some cases highest quality.

z. eValue8: A quality assessment of TPAs and other health care administrative service organizations performed by the National Business Coalition on Health and its local designees that measures and evaluates health plan performance.

aa. Fully Insured Members: Members included in the Contractor's book of business for which the Contractor receives a fixed monthly premium and assumes financial responsibility for the enrollees' medical claims and for all incurred administrative costs. For the purposes of this contract, the Contractor's Fully Insured Members shall exclude Medicaid, CHIP and Medicare members.

bb. Flexible Spending Arrangement ("FSA"): A health flexible spending arrangement allows employees to be reimbursed for medical expenses. FSAs are usually funded through voluntary salary reduction agreements with employers. No employment or federal income taxes are deducted from employee contributions. The employer may also contribute.

cc. Go-Live or Go-Live Date: January 1, 2022

dd. H&W Center: ParTNers Health & Wellness Center (i.e. onsite employee clinic).

ee. Healthcare Common Procedure Coding System ("HCPCS"): The Healthcare Common Procedure Coding System is a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology.

ff. Head of Contract: Eligible employee, retiree, surviving dependent, or individual qualified under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) who is enrolled in one of the medical benefit options of the Plans and considered to be the primary policyholder.

gg. Health Savings Account ("HSA"): A tax-exempt trust or custodial account set up with a qualified trustee for individuals covered under a qualifying high Deductible health plan to save or pay for certain medical expenses not covered by the health plan.

hh. HIPAA: Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and implementing regulations.

ii. HITECH: Health Information Technology for Economic and Clinical Health Act Title XIII of Division A and Title IV of Divison B of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5 (Feb. 17, 2009) and implementing regulations.

jj. Information System(s): A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, *i.e.*, structured data (which may include digitized audio and video) and documents as well as non-digitized audio and video; and/or (b) the processing of information and non-digitized audio and video for the purposes of enabling and/or facilitating a business process or related transaction.

kk. In Writing: Written communication between the Parties, which may be in the form of an official memo, or documents sent via post mail, fax, or email communications.

ll. Key Performance Indicators ("KPI"): Performance indicators which are the metrics used to measure and evaluate Contractor's performance against the desired outcomes. These indicators are used to determine Contractor's At-Risk Performance Payment as set forth in Contract Section C and Contract Attachment D.

mm. Leapfrog Surveys: Surveys conducted by the nonprofit Leapfrog Group that assess the safety and quality of healthcare facilities.

nn. Local Education Agency ("LEA"): A local education agency pursuant to Tenn. Code Ann. § 49-3-302.

oo. Local Government Agency ("LGA"): A local government agency pursuant to Tenn. Code Ann. § 8-27-207.

pp. Maximum Allowable Charge ("MAC"): The maximum reimbursement rate the health plan will allow as payment for the cost of services such as procedures, professional fees, technical fees, or prescribed medicines. This amount is established by the Contractor.

qq. Member: Employees and their dependents, retirees and their dependents and/or survivors, and individuals qualified under The Federal Consolidated Omnibus Budget Reconciliation Act ("COBRA") and their dependents who are enrolled in the health plan options sponsored by the State, Local Education, and Local Government Insurance Committees.

rr. National Provider Identification Number ("NPI"): A 10-position, intelligence-free numeric identifier (10-digit number). The numbers do not carry other information about health care providers, such as the state in which they live or their medical specialty.

ss. **NCQA:** National Committee for Quality Assurance is a non-profit organization dedicated to improving health care quality. **NCQA** accredits and certifies a wide range of health care organizations.

tt. Network Provider: An entity or individual (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, laboratory, durable medical equipment supplier, pharmacy etc.) that has an agreement with the Contractor to provide covered medical, pharmaceutical, or other health care services to plan Members and submits claims for reimbursement according to specific terms and rates within a specific network.

uu. Out-of-Network: The services received and the benefit level available, when delivered by providers that do not have a contractual agreement with the Contractor to provide covered medical or pharmaceutical services according to specific terms and rates within a specific network.

vv. Out-of-Pocket Maximum: The sum of any Deductibles, Copayments or Coinsurance required or incurred for any covered benefit up to a limit as defined by the Plan.

ww. Out-of-Network Provider: An entity or individual (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, laboratory, durable medical equipment supplier, pharmacy etc.) that does not have an agreement with the Contractor to provide covered medical, pharmaceutical, or other health care services to Members and submits claims for reimbursement.

xx. Paid Claim: A claim that meets all coverage criteria of the Plans and is paid by the Contractor and submitted to the State for reimbursement.

yy. Patient Centered Medical Home ("PCMH"): A model of care, typically primary care but can include specialty care, that puts patients at the forefront of care. PCMHs build better relationships between patients and their clinical care teams.

zz. Payment Reform: A state-wide initiative to transition Tennessee's healthcare payment system to better reward patient-centered, high-value health care outcomes for all Tennesseans. The Tennessee Health Care Innovation Initiative is led by the Division of TennCare and the Division of Benefits Administration, and is engaged with a broad group of stakeholders, including the largest private insurers in Tennessee and leading Tennessee healthcare providers.

aaa. Pharmacy Benefits Manager ("PBM"): State's Contractor which provides pharmacy benefit management services.

bbb. Pended Claim: A claim that is suspended or held in the claims adjudication system until the missing or inconsistent information that is required to complete claims processing can be updated on the claim.

ccc. PEPM: Per Employee per month. For purposes of this definition, "employee" shall include any enrollee in the Plans and who is also a Head of Contract

ddd. Plan Group: One of three or more groups: the State Plan (comprised of the Central State as one employer as well as the University of Tennessee as another employer and the Tennessee Board of Regents which is comprised of many different campuses and employer groups), the Local Education Plan (many different school systems), or the Local Government Plan (many different city or county governments or quasi-governmental entities).

eee. Plan Documents: The legal publications that define eligibility, enrollment, benefits and administrative rules of the Plans.

fff. Point Solution: A service or program offered within the benefits program that fills a gap in the healthcare system. Such solutions may be delivered via an alternative delivery model such as interactive video conferencing or an interactive mobile application. Such solutions are often focused on a specific condition or developed to solve specific challenges.

ggg. Population Health and Wellness Contractor(s) ("PH/W"): State's Contractor responsible for the majority of population health and wellness programs (web portal, disease management, lifestyle counseling, weight management, biometric screenings, challenges, incentive tracking, reporting, etc.).

hhh. Preferred Provider Organization ("PPO"): A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers, while also offering access to Out-of-Network Providers at an additional cost.

iii. Prior Authorization ("PA") - A program requirement where certain health care services, treatments, or procedures must gain approval before services are rendered and payment can be authorized.

jjj. Protected Health Information ("PHI"): As defined in the HIPAA Privacy Rule, 45 CFR § 160.103.

kkk. Public Key Infrastructure ("PKI"): The framework and services that provide for the generation, production, distribution, control, accounting, and destruction of public key certificates. Components include the personnel, policies, processes, server platforms, software, and workstations used for the purpose of administering certificates and public-private key pairs, including the ability to issue, maintain, recover, and revoke public key certificates.

lll. Public Sector Plans ("Plans"): Refers to all benefit options sponsored by the State, Local Government, and Local Education Insurance Committees (e.g. health plan options, life insurance, other voluntary benefits). The Plan is available to eligible employees and dependents of participating State (Central State and Higher Education), Local Government, and Local Education agencies.

mmm. Rebate: All revenue received by the Contractor (including rebate aggregators or any similar contracted entities) from outside sources related to plan member utilization of medications (including specialty medications), durable medical equipment, medical services, and devices that are paid for through the medical benefit. Also, the amounts paid to the contractor (i) pursuant to the terms of an agreement with a manufacturer or a contracted Network Provider or facility, (ii) in consideration for the inclusion of such manufacturer's product(s) on the Contractor's Formulary, the Contractor's contracted Pharmacy Benefits Manager's formulary, Contractor's covered medical services, or the Contractor's durable medical equipment and device lists and (iii) which are directly related and attributable to, and calculated based upon, the specific and identifiable utilization of certain drugs, durable medical equipment, medical services or devices by Members. These would include: access fees, market share fees, Rebates, Specialty Drug Rebates, specialty pharmacy claims, biosimilar drugs, service fees, rebate administrative fees and marketing grants from pharmaceutical manufacturers, wholesalers and data warehouse contractors, discounts, credits, inflation protection, charge backs, commissions, and any fees received for sales of utilization data to a manufacturer.

nnn. RFP: Request for Proposals.

ooo. Section 508: To ensure accessibility among persons with a disability, the Contractor's multimedia/video tools, website, social media content, and any other applicable Member content shall substantially comply with Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d) and implementing regulations at 36 CFR 1194 Parts A-D.

ppp. Service Level Agreement ("SLA") Scorecard: Performance management scorecard that contains Contractor's KPIs and desired outcomes in Contract Attachment D. The At-Risk Performance Payments will be based on the Contractor's ability to meet the listed KPIs.

qqq. Span of Control: Information Technology and telecommunications capabilities that the Contractor itself operates or for which it is otherwise legally responsible according to the terms and conditions of this Contract. The Span of Control also includes Systems and telecommunications capabilities outsourced by the Contractor.

rrr. Specialty Drugs: Medications and biologicals used in the treatment of complex clinical conditions. These agents require special handling and/or close supervision or clinical management and tend to be very expensive. They would meet at least two of the first four criteria (1 thru 4) below and the final criteria (5):

(1) Produced through DNA technology or biologic processes
(2) Targets a chronic and complex disease
(3) Route of administration could be inhaled, infused or injected
(4) Unique handling, distribution and/or administration requirements
(5) Requires a customized medication management program that includes medication use review, patient training, and coordination of care and adherence management for successful use such that more frequent monitoring and training is required.

sss. Splash Page: Dedicated and customized webpage for this Contract containing program information, specific to the Plan, which does not require a Member to log in.

ttt. State, Local Government, and Local Education Insurance Committees: Policy making bodies for the State, Local Government, and Local Education Plans established under Tenn. Code Ann. §8-27-101, 8-27-207, and 8-27-301 respectively.

uuu. State Holidays: Days on which official holidays and commemorations as defined in Tenn. Code Ann. §15-1-101 *et seq*. are observed.

vvv. Third Party Administrator ("TPA"): The State's contracted medical contractor(s) responsible for processing medical claims and providing other administrative support for the contract.

A.3. Implementation

a. The Contractor's call center and other Information Systems, including but not limited to its claims management system, shall be fully operational on January 1, 2022 (Go-Live).

b. The Contractor shall implement the Information Systems and other processes required to process all medical claims and perform all other services described herein. The Contractor shall work with the State to ensure that the Contractor satisfies applicable requirements of this Contract, including requirements in the Plan Documents (which are located on the State's website and all applicable state and federal law.

c. The Contractor shall have a Designated full-time implementation manager who is responsible for leading and coordinating all contract implementation activities as well as a Designated implementation team. Unless otherwise directed by the State, the implementation manager should be Designated full-time to this implementation project through sixty (60) days after Go-Live. All other implementation team members that the Contractor referenced in its proposal to the State shall be approved by the State and shall be available as needed during the implementation but should be Designated to this project at least two (2) months prior to Go-Live and at least thirty (30) days after Go-Live. The Contractor's implementation team shall include a full-time Account Executive Dedicated to this Contract, who will be the main contact with the State for all of the day-to-day matters relating to the implementation and ongoing operations of this Contract. Also, the Contractor shall assign an Information Systems project coordinator to coordinate information technology activities among the Contractor and the State's existing contractors and all internal and external participating and affected entities. All of the Contractor's implementation team members shall have participated, as team members, in the implementation of claims administration services for at least one other large employer (*i.e.*, employer with medical plans covering at least 30,000 lives).

d. All key Contractor project staff shall attend a project kick-off meeting at the State offices in Nashville, TN, or virtually as necessary, within the first thirty (30) days after the Contract effective date. State staff shall provide access and orientation to the Plans and system documentation, as requested by the Contractor.

e. The Contractor shall provide a project implementation plan to the State no later than thirty (30) days after the Contract effective date (refer also to Contract Attachment B, Liquidated Damages). The plan shall be electronically maintained, daily, in a format accessible to the State. The plan shall comprehensively detail all aspects of implementation, which includes all tasks with deliverable dates necessary to satisfactorily implement all medical claims administrative services no later than Go-Live, a description of the members on the implementation team and their roles with respect to each item/task/function. The plan shall include a detailed timeline description of all work to be performed both by the Contractor and the State. This plan shall require written approval by the State. At a minimum, the implementation plan shall provide specific details on the following:

(1) identification and timing of significant responsibilities and tasks;
(2) identification and timing of deliverables and milestones;
(3) names and titles of key implementation staff;
(4) identification and timing of the state's responsibilities;
(5) data requirements (indicate type and format of data required);
(6) identification and timing for the testing, acceptance and certification of receipt of the State's enrollment information;
(7) identification and timing for testing and certification of claims processing and payment and the reconciliation process;
(8) Member communications;
(9) schedule of in-person meetings and conference calls;
(10) transition requirements with the incumbent claims administrator(s); and
(11) staff assigned to attend and present (if required) at annual transfer/ educational sessions.

f. At the State's request, the Contractor shall provide for a comprehensive operational readiness review by the State, and/or its authorized representative, within sixty (60) days prior to Go-Live (refer also to Contract Attachment B, Liquidated Damages). Such review by the State, and/or its authorized representative, may include, but not be limited to, an onsite review of the Contractor's operational readiness for all services required in this Contract (*e.g.*, member services, call center cultural readiness, training, and website development). The review may also include reviews of documentation that includes but is not limited to:

(1) policy and procedures manual;
(2) call center scripts;
(3) Information Systems documentation; and
(4) the ability to provide, and the process governing the preparation of, any and all deliverables required under this Contract.

g. The State and/or its authorized representative shall also conduct an additional, pre-implementation review of the Contractor's progress towards fulfilling the Information Systems and claims processing and payment requirements of this Contract. Such review by the State, and/or its authorized representative, may include onsite or remote reviews, including but not limited to staff interviews, system demonstrations, systems testing, and document review.

h. During onsite visits as part of a readiness review or a pre-implementation review, the Contractor shall provide onsite workspace and access to a telephone, scanner, printer, copy machine, and Internet connection. The Contractor's staff members shall be freely available to the State officials to answer question during this visit.

i. The Contractor shall conduct status meetings with the State concerning project development, project implementation and Contractor performance at least weekly during implementation and the first month following Go-Live, unless otherwise approved by the State. Thereafter, all ongoing operational meetings shall be conducted on a State-specified schedule, but shall occur no less than weekly unless otherwise directed by the State. Such meetings shall be either by phone or onsite at the offices of the State, as determined by the State, and shall include the Account Executive, Account Manager, and other appropriate Contractor staff. Any costs incurred by the Contractor as a result of a meeting with the State shall be the responsibility of the Contractor.

j. No later than forty-five (45) days post Go-Live, the State shall complete an Implementation Performance Assessment survey of the Contractor's performance to determine the State's satisfaction with the implementation process and Contractor. Results shall be shared with the Contractor including the identification of any deficiencies. The Contractor shall respond within fifteen (15) days of receiving the results with a corrective action plan as necessary to remedy any identified deficiencies. In response to the corrective action plan, the Contractor shall comply with all recommendations and requirements agreed upon by the State within the timeframes agreed upon by the State.

k. "Lessons Learned" Debriefing. The Contractor shall conduct a self-assessment regarding implementation of this Contract, prepare a report summarizing its findings, including success, challenges, and lessons learned, and provide an in-person or remote debriefing presentation to the State. The report and presentation shall be provided to the State no later than ninety (90) days post Go-Live.

A.4. Administrative Services

a. The Contractor, upon request by the State, shall review and comment on proposed revisions to the benefits in the Plans. When so requested, the Contractor shall comment in regard to:

(1) industry best practices;
(2) the overall cost impact to the Plans;
(3) any potential cost impact to the Contractor's fee;
(4) impact upon utilization management performance standards;
(5) impact upon the Contractor's performance;
(6) necessary changes in the Contractor's reporting requirements; and/or
(7) system changes.

b. The Contractor shall collaborate and assist with questions regarding effective dates, benefits, cost-sharing and cessation of coverage as requested by the State, Members, and providers.

c. The Contractor shall keep the State apprised (through such methods as policy briefs, white papers, client communications, etc.) of any new or recently discovered federal or state laws, rules or policies that may impact the Plans. The Contractor shall collaborate with the State on any recommended actions in order to comply with such laws, rules or policies.

d. The Contractor shall refer calls from ABCs regarding eligibility or enrollment systems issues to the State.

e. The Contractor shall respond to all inquiries In Writing from the State within two (2) Business Days after receipt of said inquiry. In cases where additional information to answer the State's inquiry is required, the Contractor shall notify the State immediately as to when the response can be furnished to the State. For matters designated as urgent by

the State, the Contractor shall provide a response to the State within four (4) hours during normal business hours. During non-business hours the Contractor shall provide a response to urgent matters to the State within twenty-four (24) hours. Staff members, from the applicable business unit, with final decision making authority shall provide responses.

f. The Contractor shall cooperate with the State in analyzing the impact of proposed legislation on the operation of the Contract. Unless otherwise directed by the State, the Contractor shall respond In Writing with a summary of Plan impact and cost breakdown analysis to all inquiries from the State regarding responses to proposed legislation within forty-eight (48) hours of the State's request. The Contractor shall defer to the State's interpretation of the applicability of proposed legislation to the State Plans. The Contractor's analysis shall include legislation that is not directly applicable to the State Plans but which may indirectly affect the Contract by increasing the cost of Contractor's operations.

g. The Contractor shall meet with authorized representatives of the State, at the request of either party, periodically to discuss any problems and/or progress on matters outlined by the State. The Contractor shall have in attendance the staff requested by the State, which may include a Program Director and representatives from the Contractor's organizational units required to respond to topics indicated by the State's agenda.

h. No less than semi-annually, the Contractor shall meet with the State to provide information concerning its efforts to develop cost containment mechanisms, value based initiative outcomes, administrative improvements, as well as trends in the provision of benefits. The Contractor shall provide advice, assistance and information to the State regarding applicable existing and proposed federal and state laws and regulations affecting the Plans. The Contractor shall also provide information to the State regarding the administration of the benefit, cost and utilization trends, utilization management, internal procedures for billing and reconciliation of transactions, the provision of medical treatment, fraud and abuse activities, and other administrative matters. These meetings will typically occur at the State of Tennessee offices in Nashville, TN, however, at its discretion, the State may request for the meeting to take place by teleconference.

i. The Contractor shall determine medical eligibility of Members who are enrolled as incapacitated dependent children and report the results to the State. All incapacitated dependent children must be verified as incapacitated prior to their 26th birthday to determine their future enrollment in the Plan. The Contractor shall also verify continued incapacitation of currently enrolled incapacitated dependent children at regular intervals, as appropriate, based on the likelihood of a change in the status of the incapacitation.

j. The Contractor shall refer all media and legislative inquiries to BA, which will have the sole and exclusive responsibility to respond to all such inquiries. However, the Contractor shall respond directly to audit requests from the Comptroller, to audit requests from divisions within the Department of Finance & Administration, and to subpoenas; in all such instances, the Contractor shall copy the State on all correspondence.

k. The Contractor's system(s) shall possess mailing address standardization functionality in accordance with U.S. Postal Service conventions.

l. Unless prior approved In Writing by the State, and in compliance with state and federal law, the Contractor shall not use information gained through this Contract, including but not limited to Member information, utilization, and pricing information, in marketing or expanding non-State business relationships or for any pecuniary gain.

m. If requested by the State, the Contractor shall attend State-sponsored contractor summits with representatives from the State, and its other contracted health plan contractors. The purpose of the contractor summit is to identify issues, develop solutions, share

information, leverage resources, and discuss and develop policies and procedures as necessary to ensure collaboration among contractors and the State.

n. The Contractor shall notify the State, within three (3) Business Days of identification, about any situation that appears to negatively impact the administration or delivery of the program, plan, or benefits, including but not limited to, file and data sharing between contractors. (Refer to Attachment D, SLA Scorecard.) The situation shall be researched and resolved in a timeframe mutually agreed upon with the State.

o. The Contractor shall provide the service of transitioning all existing services awarded under this contract to the next awarded contract holder at no additional cost to the State. A written transition plan shall be provided to the State within nine (9) months prior to the end of the current Contract.

A.5. Staffing

a. The Contractor shall provide and maintain qualified staff to provide services required under this Contract. The Contractor shall ensure that all staff, including the Contractor's employees, independent contractors, consultants, and subcontractors, performing services under this requirement have the experience and qualifications to perform the applicable services.

b. For its work under this Contract, the Contractor shall not use any person or organization that is on the U.S. Department of Health and Human Services' Office of Inspector General (OIG) exclusions list. unless the Contractor receives prior, written approval from the State.

c. The Contractor shall ensure that all staff receives initial and ongoing training regarding all applicable requirements of this Contract and the Plans. The Contractor shall ensure that staff providing services under this Contract are specifically oriented and trained regarding their functions, knowledgeable about the Contractor's operations relating to the Plans, and knowledgeable about their functions and how those functions relate to the requirements of this Contract.

d. The Contractor shall have on staff sufficient qualified and licensed nurses and physicians whose primary duties are to conduct medical necessity reviews of claims, including review of complex or questionable medical claims.

e. The Contractor's utilization management (UM) reviewers, or subcontractor reviewers, shall be familiar with the terms of the Plan Documents. The UM reviewers shall consist of qualified nurse reviewers and physician reviewers. The Contractor shall exercise due diligence and care in its selection and retention of staff that perform UM services. The Contractor shall offer providers uninterrupted telephone access to UM reviewers continuously during the Contractor's normal business hours.

f. The Contractor shall have an ongoing Designated, full-time Account Team that can provide daily operational support as well as strategic planning and analysis. All members of the Account Team shall have previous experience administering medical benefits for large employers. An available member of the Account Team shall be available for consultation with the State during the hours of 8:00 a.m. to 4:30 p.m. Central Time, Monday through Friday, as required to fulfill the scope of services specified in this Contract.

g. The Contractor shall Dedicate a full time Account Executive and Account Manager as members of the account team. The Account Executive shall have the responsibility and authority to manage the entire range of services specified in this Contract and shall respond promptly to changes or inquiries in benefit plan design, changes or inquiries in

claims processing procedures, or general administrative issues identified by the State. The Account Manager shall have the responsibility and authority to respond promptly to Member, claims, and provider issues or inquiries as identified by the State. At a minimum, the Account Executive shall meet in person with the State semi-annually and more often if required by the State. At its discretion, the State may allow the Contractor to participate in such meetings by teleconference. The Account Executive shall also be available via cell phone and email after hours, including weekends.

h. The State shall perform an account satisfaction survey of the Contractor's performance annually during the contract period to determine the State's satisfaction with the ongoing account team and Contractor. Results shall be shared with the Contractor including the identification of any deficiencies. The Contractor shall respond within fifteen (15) days of receiving the results with a corrective action plan as necessary to remedy any identified deficiencies.

i. The Contractor agrees that the State may approve or disapprove the staff assigned to this Contract prior to the proposed assignment including approving the implementation and account teams. The State may also direct the Contractor to replace staff members providing core services as it deems necessary and appropriate. The decision of the State on these matters shall not be subject to appeal.

j. Key personnel commitments made in the Contractor's proposal shall be approved In Writing during implementation and shall not be changed unless prior approved by the State In Writing. The Contractor shall notify the State at least fifteen (15) Business Days in advance, or as soon as the information is available, of proposed changes and shall submit justification (including proposed substitutions) in sufficient detail regarding education and experience equal to previous staff to the State to evaluate the impact upon the Contract. The decision of the State on these matters shall not be subject to appeal.

k. If any key position becomes vacant, the Contractor shall notify the State within two (2) weeks of identifying said vacancy and provide a replacement, subject to final approval by the State, with commensurate experience and required professional credentials within sixty (60) days of the vacancy unless the State grants an exception to this requirement In Writing.

A.6. Provider Network

a. The Contractor shall maintain a PPO Efficient Network that serves Members covered by this Contract in all ninety-five (95) Tennessee counties, as well as Members residing or traveling outside of the state. This Efficient Network shall provide high quality, cost effective medical services, and adequate geographic and service access to Members. Unless otherwise directed by the State, the network shall include other commercial clients and cannot be established only for State Members. The Contractor shall contract with medical providers including, but not limited to, primary care physicians, specialist physicians, nurse practitioners/physician assistants, nurse midwives, hospitals (all levels - primary, secondary and tertiary), skilled nursing facilities, urgent care facilities, convenience clinics, state employee onsite clinics, laboratories, durable medical equipment suppliers, and all other medical facilities, services and providers necessary to provide covered benefits.

b. At the request of the State, the Contractor shall implement their PPO Broad Network (statewide and national), that provides high quality, cost effective medical services, and includes all major hospital facilities/systems and major provider groups. At the State's request, the Contractor shall add any requested provider to the network, assuming they meet all of the Contractor's quality and credentialing requirements and are agreeable to market competitive reimbursement rates. Unless otherwise directed by the State, the network shall include other commercial clients and cannot be established only for State

Members. The Contractor shall contract with medical providers including, but not limited to, primary care physicians, specialist physicians, nurse practitioners/physician assistants, nurse midwives, hospitals (all levels - primary, secondary and tertiary), skilled nursing facilities, urgent care facilities, convenience clinics, state employee onsite clinics, laboratories, durable medical equipment suppliers, and all other medical facilities, services and providers necessary to provide covered benefits.

c. The Contractor's provider network(s) proposed in the RFP and throughout the service period shall meet, at a minimum, the geographic access standards specified in Contract Attachment B, Liquidated Damages.

d. The Contractor shall provide the State with geographic access reports on a quarterly basis showing service and geographic access standards compliance (refer also to Contract Attachment B, Liquidated Damages and Attachment C, Reporting Requirements). The State shall inform the Contractor of acceptable geographic access report companies and shall provide the approved data analysis, report format, and an updated Tennessee ZIP code list for each report delivery period. At the State's request, the Contractor shall also submit an access report following a network change. The State shall review the reports and inform the Contractor In Writing of any deficiencies. The Contractor shall develop and implement an action plan to correct deficiencies. The State reserves the right to review the action plan and require changes, where appropriate.

e. The Contractor shall maintain sufficiently extensive and accessible provider networks, both Efficient and Broad, such that Members are able to receive appointments from a geographically-accessible provider within the following appointment standards:

(1) urgent visit: twenty-four (24) hours
(2) wellness visit: two (2) months
(3) primary care routine visit: fourteen (14) days
(4) specialty care routine visit: thirty (30) days

f. The Contractor shall ensure that no specific payment be made directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

g. The Contractor shall maintain a record of all voluntary and involuntary network changes including any additions, deletions, terminations and reason for change, in the Contractor's provider network(s) and shall provide a report of said changes upon request by the State.

h. The Contractor shall notify the State In Writing of any termination of a hospital, physician group of ten (10) or more, or a physician group providing care that would be eligible for continuity of care exceptions, regardless of whether the termination is initiated by the Contractor or the provider, within one (1) business day of becoming aware of the termination. The Contractor shall also provide written notice to Members who received treatment from the hospital or physician group within a minimum of the last six (6) months. Unless otherwise directed by the State, the Contractor shall mail the notice to Members no less than thirty (30) calendar days prior to the effective date of the termination. In instances of hospital closures, the Contractor shall mail written notice to impacted Members within thirty (30) calendar days of the closure and include a list of the closest network hospital(s). Refer also to Contract Attachment B, Liquidated Damages.

i. The Contractor shall not take action to disenroll network primary care providers or hospital providers except for good reason, which may include: inability to negotiate continuance of its provider agreement; provider failure in the credentialing/recredentialing process; non-compliance with provider agreement requirements; provider request for disenrollment; Member complaints; suspicion of provider impairment; loss of license or exclusion from participation in Medicare or Medicaid pursuant to Sections 1128 or 1156

of the Social Security Act; or those who are otherwise not in good standing with the Plans.

j. The Contractor shall give affected providers written notice if it declines to include individual or groups of providers in its network.

k. The Contractor shall maintain a current record of network physicians not accepting Members as new patients and shall provide a report upon request by the State.

l. The Contractor shall maintain a record of provider turnover that includes the Contractor's voluntary and involuntary turnover rate by provider type and shall provide a report upon request by the State.

m. The Contractor shall contract only with providers who are duly licensed to provide such medical services and shall require that all providers maintain all licenses and accreditations in existence at the time of selection as a Network Provider in order to continue their status as a Network Provider. The Contractor shall perform on a continuous basis appropriate provider credentialing that assures the quality of Network Providers. The Contractor shall complete processes necessary to reconfirm the licensure, accreditations, credentials, and standing of Network Providers no less frequently than every three (3) years.

n. The Contractor shall maintain face-to-face, telephonic, and written communication with providers to ensure a high degree of continuity in the provider network and ensure that the providers are familiar with applicable requirements.

o. The Contractor shall maintain a provider Denied Claim appeals policy and process and shall provide the State with a copy of said process thirty (30) days prior to Go-Live. The Contractor shall provide the State with a list of provider Denied Claim appeals every quarter (refer also to Contract Attachment C, Reporting Requirements). The State shall select a random sample of Denied Claim appeals from the report for further review and explanation. The Contractor shall complete a question log based upon the Contractor's documented process regarding the selected Denied Claim appeals. The completed log shall be maintained by the State on record as verification of contractor compliance with internal policy.

p. The Contractor shall notify all Network Providers of, and enforce compliance with, all provisions relating to utilization management and other procedures as required for participation in the Contractor's provider network.

q. The Contractor shall require all Network Providers to file claims associated with their services directly with the Contractor on behalf of Members.

r. In no case shall Network Providers Balance Bill for covered benefits. Rather, the Member's liability shall be limited to the allowable Member cost-sharing.

s. The Contractor shall identify and sanction Network Providers who fail to meet pre-determined, minimum standards relating to referrals to Out-Of-Network Providers and shall provide a report to the State upon request In Writing.

t. The Contractor shall notify the State In Writing at least thirty (30) days prior to any material adjustments to any provider payment terms, including but not limited to provider fee schedules, contract rates, other provider payment arrangements, discounts, rebates, refunds, or credits negotiated with the provider, and the manner in which such adjustments are reasonably likely to affect the cost of claims payments by the State. Such notification shall be made for all hospitals, physician groups of twenty (20) or more, or broad classification of providers.

u. If a Member is undergoing active treatment with an Out-of-Network Provider for a serious medical condition at Go-Live or upon newly enrolling in the Plans, the Contractor shall arrange for a transition of care agreement with the Out-of-Network Provider. Members or their authorized representative have the greater of thirty (30) days from Go-Live or benefit effective date to request a transition of care exception. The Member's financial liability shall be limited to any cost-sharing (e.g., in-network Copayment, Coinsurance and Deductible amounts) that would have applied if the treating provider was a Network Provider. The Out-of-Network Provider shall be reimbursed at the MAC or other negotiated amount throughout the approved transition of care period with an agreement to accept said rate as payment in full.

v. If a Member is undergoing active treatment for a serious medical condition when a provider leaves the network, the Contractor shall arrange for a continuity of care agreement with the terminating provider. Members or their authorized representative have the greater of thirty (30) days from the date of provider termination or thirty days from notification of the termination (either by written notice, EOB, or other means) to request a continuity of care exception. The Member's financial liability shall be limited to any cost-sharing (*e.g.*, in-network Copayment, Coinsurance and Deductible amounts) that would have applied prior to the provider leaving the network and the terminating provider shall be reimbursed at their terminated contracted rate throughout the approved continuity of care period with an agreement to accept said rate as payment in full.

w. If the Contractor is unable to deliver covered benefits and medically necessary care through Network Providers, the Contractor shall arrange for such services to be rendered by Out-Of-Network Providers. Unique care exceptions due to network adequacy should be requested and reviewed prior to a Member receiving services. A unique care exception may be approved by the State In Writing, retroactively in a critical care situation if the carrier would have otherwise approved the care. When the Contractor arranges for covered benefits to be provided through an Out-Of-Network Provider, the Member's financial liability shall be limited to any cost-sharing that would have applied had the service been rendered by a Network Provider (*e.g.*, in-network Copayment, Coinsurance, and Deductible amounts), except expenses determined not to be medically necessary and expenses that exceed the Maximum Allowable Charge, unless otherwise directed by the State.

x. The Contractor shall report to the State on a monthly basis all transition of care, continuity of care, and unique care exception requests, whether they were granted or denied, and any reason for approval or denial (refer also to Contract Attachment C, Reporting Requirements).

A.7. Member Services

a. All member services representatives handling inquiries related to the Plans shall be familiar with the terms and provisions of the Plan Documents, including without limitation, eligibility, benefits, excluded services and procedures, Deductibles, applicable cost-sharing, including Copayments and Coinsurance, out-of-pocket maximums, instructions for completing a claim form, determining the status of claims, how to handle a complaint, and the Member appeals process.

b. During normal business hours, the Contractor's member services representatives shall be Dedicated to the Plans. A Contractor may be allowed, by the State In Writing, to use a Designated call unit (as opposed to a Dedicated call center) provided that the unit could meet all other call center standards defined in this Contract.

c. The Contractor shall have sufficient member services representative staff to respond to Member inquiries, correspondence, complaints, and problems related to all aspects of the services required in this contract such as network development or changes, claims

processing, appeals, provider participation and use of the Contractor's online tools described in Contract section A.15. Member services representatives shall connect or warm transfer Members to other State contractors for benefit services as needed based upon the Member's inquiry or issue. The Contractor shall not answer technical questions regarding eligibility policy and shall refer these questions to the State.

d. The Contractor shall have healthcare navigators and advocacy staff to support Members with resources and services, including but not limited to:

(1) educating Members on how to understand their EOBs and provider bills;
(2) working with Members and providers on claims and billing resolution;
(3) finding high quality low cost providers;
(4) encourage participation in value based initiative programs and participating providers;
(5) maximizing benefits;
(6) closing gaps in care;
(7) navigating denials and appeals;
(8) recommending Contractor sponsored expert medical opinion services and/or case management; and
(9) connecting or warm transferring to other State contractors for benefit services.

e. Member services representatives and healthcare navigators shall be fully trained on the contractor's website to guide Members through website navigation to review claims, find Network Providers, identify provider quality ratings, estimate future medical costs, and access additional contractor resources.

f. The member services representatives and healthcare navigators shall be trained to direct Members to high performance high quality Network Providers and/or facilities particularly when there are associated Member benefit incentives.

g. The Contractor shall provide appointment scheduling assistance to Members who are unable to secure an appointment with a geographically-accessible Network Provider within the timeframes specified in Contract Section A.6.e. The State defines appointment scheduling assistance to include the following: (1) if the Member is unable to secure an appointment with a Network Provider within a reasonable period of time through the Member's own good faith efforts and the Member requests the Contractor's assistance, then the Contractor has an affirmative obligation to contact the provider directly to facilitate appointment scheduling. Additionally, (2) if a member is unable to locate a Network Provider who is accepting new patients through their own good faith efforts and the Member requests the Contractor's assistance, then the Contractor has an affirmative obligation to assist the Member in locating such a Network Provider and securing an appointment.

h. The Contractor shall have and implement procedures for monitoring and ensuring the quality of services provided by its member services representatives. Such procedures may include, but are not limited to, the following activities:

(1) auditing calls/correspondence for each member services representative;
(2) silent monitoring of calls;
(3) recording calls for quality and training purposes;
(4) skill refresher courses; and
(5) call coaching.

i. The Contractor shall set standards for customer satisfaction for member services representatives based upon, but not limited to, an evaluation of the following areas: documentation, greeting, courtesy, responsiveness, explanation and guiding techniques, and accuracy. The standards shall be disclosed to the State no later than thirty (30) days

prior to Go-Live. Adherence to the standards shall be measured, monitored and reviewed by the Contractor according to Contractor policies and procedures.

j. The Contractor shall evaluate member services representative calls per Contractor policies and procedures in order to assess the call handling quality and shall report the findings to the State as requested.

k. The Contractor shall provide a personalized response, In Writing, to ninety-five percent (95%) of written (mail or email) inquiries from Members concerning requested information, including the status of claims submitted and covered benefits, within five (5) Business Days and ninety-nine (99%) within ten (10) Business Days. The Contractor shall acknowledge receipt of email inquiries from Members or the State within one (1) Business Day.

l. The Contractor's Dedicated Account Manager shall respond to Member-related issues identified by the State. For matters designated as urgent by the State, the Contractor shall contact the Member and resolve the issue and then notify the State of the resolution.

m. The Contractor shall maintain a procedure for resolving complaints informally by phone, including reconsiderations and initiating peer to peer reviews. Where a complaint cannot be resolved to the Member's satisfaction, the Contractor shall advise the Member of his/her right to file an appeal and shall provide instructions and assistance as needed by the Member for doing so.

n. Unless otherwise directed by the State, the Contractor shall conduct an annual member satisfaction survey using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) adult survey. The Contractor shall contract with a contractor that is certified by NCQA to perform CAHPS surveys, and the contractor shall perform the CAHPS adult commercial survey. The Contractor shall report the results of the survey to the State by July 20 of each calendar year (refer also to Contract Attachment D, Service Level Agreement and Attachment C, Reporting Requirements). The level of overall customer satisfaction shall be equal to or greater than eighty-five percent (85%) in the first year of the Contract, and shall be equal to or greater than ninety percent (90%) in all subsequent year(s) within the contract term. Based upon the results of the survey, the Contractor shall also develop an action plan to correct problems or deficiencies identified through this activity and deliver said action plan with the CAHPS survey results. The State reserves the right to review the action plan and require changes, where appropriate.

A.8. Member Appeals Process

a. The Contractor shall maintain an appeals process in compliance with Section 2719 of PPACA (42 U.S.C. 300gg-19), 45 CFR 147.136, and the Plan Document, including all minimum consumer protection standards, by which Members may appeal adverse benefit determination decisions including, but not limited to, determinations based on: medical necessity; appropriateness; health care setting; level of care; medical effectiveness; determinations that treatments are experimental or investigational; whether treatments are "emergency care" or "urgent care"; coverage of items or services based on medical conditions; frequency, method, treatment, or setting of recommended preventive services to the extent not specific in HHS's published lists of recommended preventive services; whether the plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act; if applicable, whether participants or beneficiaries are entitled to a reasonable alternative standard for a reward under a wellness program; and a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time). If any part of section A.8. conflicts with the

federal review and appeal requirements of Section 2719 of PPACA (42 U.S.C. 300gg-19) or 45 CFR 147.136, the Contractor shall follow the federal requirements.

b. The Contractor shall maintain formal appeal procedures affording two internal reviews as well as an external independent review which allows claimants to review their file, to present evidence and testimony as part of the appeals process. The internal review(s) shall be conducted by a committee designated by the Contractor that is designed to ensure the independence and impartiality of the persons involved in making the decision. The external review shall be conducted by an Independent Review Organization (IRO).

c. The Contractor must assign an IRO that is accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. The Contractor must contract with at least three (3) IROs and rotate assignments among the IROs to prevent bias and ensure independence. The IRO cannot be eligible for any financial incentives based on the likelihood that the IRO will support a denial of benefits.

d. The Contractor shall include notification of the Member's right to appeal in any Member communication regarding benefit coverage decisions, including but not limited to, letters to Members and providers, member handbooks, and Explanation of Benefit (EOB) statements. The notices must be provided in a culturally and linguistically appropriate manner and are subject to prior written approval from the State.

e. At a minimum, the Contractor shall provide a description of available internal appeals and external review processes, including information on how to initiate an appeal, in Member handbooks, on the state specific website and any other documents as requested by the State.

f. The Contractor must provide notification of decisions within the following time frames and all decision notices shall advise of any further appeal options. Failure to do so may result in At-Risk Performance Payments as specified in Contract Attachment D, SLA Scorecard:

(1) One hundred percent (100%) of all expedited appeals for urgent care (not involving a third party review) shall be decided no later than 72 hours after receipt of the request for an expedited review for urgent care.
(2) Ninety-five percent (95%) of denied non-urgent pre-service (care not yet received) appeals shall be decided within thirty (30) days after receipt of the request.
(3) Ninety-five percent (95%) of denied non-urgent post-service (care already received) appeals shall be decided within sixty (60) days after receipt of the request.

g. The Contractor shall submit quarterly appeals reports with information regarding each appeal and associated timeline filed with the Contractor and the IROs (refer also to Contract Attachment C, Reporting Requirements).

h. The Contractor must provide continued coverage pending the outcome of an appeal. Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

i. The Contractor must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance established to assist individuals with the internal claims and appeals and external review processes.

j. Any appeals of denied requests for continued hospitalization shall be promptly processed and shall involve physician-to-physician consultation between the Contractor's staff and attending physician.

k. At least one (1) month prior to Go-Live, the Contractor shall provide the State information describing in detail the Contractor's appeals process and procedures along with copies of sample determination letters for internal and external appeals. The State reserves the right to review the appeals process and procedures and letters and require changes, where appropriate.

l. The Contractor shall ensure that all records and information related to appeals are preserved as required by other provisions of this Contract or state or federal law.

m. The Contractor shall allow a Member or their authorized representative one hundred and eighty (180) calendar days to initiate an internal appeal following notice of an adverse determination. The Contractor shall provide notice to the Member of all unfavorable internal appeal determinations and advise them of their right to initiate an external appeal within four (4) months of receiving said notice.

A.9. Utilization Management

a. Unless otherwise directed by the State, the Contractor shall maintain a utilization management (UM) function designed to help individual Members secure the most appropriate level of care consistent with their health status. In carrying out this function, the Contractor shall provide a system for reviewing the appropriateness and medical necessity of inpatient hospital care, skilled nursing facility stays, inpatient rehabilitative care, oncology (chemotherapy and radiation therapy), medical Specialty Drugs, and other levels of care included in the Contractor's standard UM programs, or as specified by the State, and for prior authorizing these and other covered benefits. The State shall have the option to approve and apply any utilization management programs and criteria developed by the Contractor, including utilization management programs performed by a subcontractor or other entity at the time of contract effective date or at any point during the contract claims processing period, and the costs shall be included in the existing administrative fees listed in Contract Section C.3.

b. The Contractor's utilization management program for this Contract shall be fully accredited by URAC. If the Contractor meets this requirement as of Go-Live, the Contractor shall maintain such accreditation throughout the period of this Contract. If the Contractor does not currently meet this requirement, the Contractor shall obtain such accreditation by December 31, 2022 (or a later date as specified by the State) and shall maintain it thereafter throughout the period of this Contract. See also Contract Attachment B, Liquidated Damages and Contract Attachment C, Reporting Requirements.

c. The Contractor shall maintain an online publicly accessible library of medical necessity coverage policies and ensure that submitted claims are processed in accordance with published policies. The State shall have the option to approve and apply any utilization management programs and criteria developed by the Contractor that replace the oversight or adherence of a published medical necessity coverage policy and the costs shall be included in the existing administrative fees listed in Contract Section C.3.

d. The Contractor shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including PA and decision making and who are familiar with the Plan Documents.

e. The Contractor shall have in place an effective process that identifies and manages Members in need of inpatient hospital care. This shall include:

(1) Identification of patients in need of inpatient hospital care for the purpose of reviewing the level of care requested, determining the extent of care required, and identifying appropriate additional or alternative services as needed; this shall

include admission review, or the pre-certification/authorization of an inpatient stay.

(2) Concurrent review during the course of a patient's hospital inpatient stay, where qualified medical management staff coordinate care with the hospital staff and patients' physicians; this shall include review of the continued hospitalization of patients and identification of medical necessity for stays as well as available alternatives.

(3) Discharge planning, providing a process by which the Contractor's UM staff work with the hospital, patient's physicians, the State's PH/W contractor as requested by the State, patient's family, and appropriate community resources to coordinate discharge and post-discharge needs of the patient and reduce the likelihood of readmission.

(4) Review of urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine medical necessity for the service.

f. The Contractor shall have in place an effective process that identifies and manages Members in need of skilled nursing facility care. This shall include:

(1) Identification of patients in need of skilled nursing care for the purpose of reviewing the level of care requested, determining the extent of care required, and identifying appropriate additional or alternative services as needed; this shall include admission review, or the pre-certification/authorization of a skilled nursing facility stay.

(2) Concurrent review during the course of a patient's skilled nursing facility stay, where qualified medical management staff coordinate care with the skilled nursing facility staff and patients' physicians; this shall include review of the continued skilled nursing facility stay of patients and identification of medical necessity for stays as well as available alternatives.

(3) Discharge planning, providing a process by which the Contactor's utilization management staff work with the skilled nursing facility, patient's physicians, PH/W contractor, as requested by the State, patient's family, and appropriate community resources to coordinate discharge and post-discharge needs of the patient and reduce the likelihood of readmission.

g. The Contractor shall not require pre-admission certification for inpatient hospital admissions for the normal delivery of children.

h. The Contractor shall require PA of the following services. Subject to State approval In Writing, the Contractor may require PA of other services.

(1) Outpatient high-technology diagnostic imaging, including but not limited to Magnetic Resonance Imaging (MRI), Computerized Tomography (CT), Positron Emission Tomography (PET) scans, and nuclear cardiac imaging studies;

(2) Home health services (including home infusion);

(3) Private duty nursing;

(4) Inpatient rehabilitation services (including pulmonary and cardiac);

(5) Hospice;

(6) Non-emergent ambulance transport;

(7) Miscellaneous HCPCS codes (including but not limited to all provider administered J-codes, Q-codes, and C-codes);

(8) Chemotherapy;

(9) Radiation therapy;

(10) Outpatient surgical procedures with documented medical policy criteria, including those performed at ambulatory surgery centers (does not apply to screening colonoscopy or provider office procedures);

(11) Genetic Testing;

(12) Medical Specialty Drugs; and

(13) Other services specified by the State, In Writing, or in the Plan Document.

i. Unless otherwise directed by the State, the Contractor shall complete ninety-seven percent (97%) of all PAs within the following standards for timeliness of PA and UM decision making. Failure to do so may result in At-Risk Performance Payments as specified in Contract Attachment D, SLA Scorecard:

(1) For non-urgent pre-certification or PA decisions, the Contractor shall make the decision within fifteen (15) calendar days of receipt of the request;
(2) For urgent PA decisions, the Contractor shall make the decision within seventy-two (72) hours of receipt of the request
(3) For urgent pre-certification or concurrent review decisions, the Contractor shall make the decision within twenty-four (24) hours of receipt of the request;
(4) For retroactive decisions, the Contractor shall make the decision within thirty (30) calendar days of receipt of the request.

j. The Contractor shall submit quarterly PA and utilization management reports with information regarding each decision outcome and associated timeline filed with the Contractor (refer also to Contract Attachment C, Reporting Requirements).

k. If the Contractor is missing any information necessary to make a pre-certification, PA, or concurrent review decision, the Contractor shall immediately contact the provider to obtain the missing information. If the information is still missing one (1) business day after contacting the provider, the Contractor shall make at least one follow-up contact to obtain the missing information.

l. The Contractor shall have an electronic UM system that contains complete (*i.e.*, sufficient to accurately portray the events of the review during an independent medical audit of the UM record) documentation of the review process by capturing administrative and clinical data as well as clinical notes by the UM staff.

m. The Contractor shall use protocols that are diagnosis/procedure specific, consistent with efficient medical practices, and that provide nurse reviewers with guidelines regarding the type of care that is indicated during each day of treatment. Physician reviewers shall be actively involved in the review process in accordance with industry standards. Any provision of the Plan Documents and any state or federal laws shall take precedence over any protocol used by the Contractor.

n. The Contractor shall maintain a comprehensive internal audit program for utilization management services and shall take prompt corrective action to correct any deficiencies or quality of care issues.

o. The Contractor shall submit to the State, at least two (2) months prior to Go-Live , a copy of all documents describing its UM program, evaluation methodology, and audit plan. The Contractor shall notify the State, In Writing, within thirty (30) days of any significant changes to its UM program.

p. The Contractor shall provide a written report to the State as requested regarding the demonstrated effectiveness of its UM program.

q. At the State's request, the Contractor shall provide expert medical opinion services for Members diagnosed with a complex medical condition or surgical interventions such as but not limited to cancer, musculoskeletal, transplant, autoimmune, renal disease, women's health, cardiac/vascular, gastrointestinal. Expert medical opinion services may be provided by the Contractor or a subcontractor and shall be reimbursed pursuant to Contract Section C.3. Services shall include an assigned Member care coordinator, medical record collection and consolidation, expert medical review by a provider within seven (7) days, provider consultation with the Member and/or Member's authorized representative, provider consultation with the Member's initial/primary provider (if

applicable), written expert medical opinion in a Member approved format (mail, secure email, electronic file, etc.), referrals to in-network specialists, and follow-up medical care coordination. Expert medical opinion services shall be available to the Member through the Contractor's call center, website, or mobile application. The Contractor shall administer Member utilization incentive options such as, but not limited to, an enhanced benefit design at the state's request. The Contractor shall also recommend the expert medical opinion service option to any Member calling the Contractor call center requesting benefit information or a PA for a qualifying condition or surgical intervention.

r. The Contractor shall submit a monthly expert medical opinion report with information on each case including but not limited to the case type, any diagnosis or treatment changes, referrals to in-network specialists, and any estimated cost savings (refer also to Contract Attachment C, Reporting Requirements).

s. The Contractor shall provide medically necessary case management services. This shall include identifying and outreaching to Members with high-risk conditions such as but not limited to terminal illness, cancer, major cardiac surgery, severe injury, major trauma, high-risk maternity, neonate admissions, cognitive or physical disability, dialysis, or transplants. Registered nurse case managers shall work with the Member, health care providers, primary caregivers and appropriate contractors to coordinate the most appropriate, cost-effective care and care settings. This shall include transition to designated contractors for continued follow-up and ongoing management, as designated by the State, as well as clinical management and oversight of activities to ensure timely and effective transition to appropriate contractors.

t. The Contractor shall identify, no less than every six (6) months, Members using emergency department services inappropriately or excessively. The Contractor shall outreach to those Members for the purpose of educating the Member on appropriate emergency department use, enrolling the Member in case management, if appropriate, or referring the Member to other State contractors for assistance (PH/W contractor or BHO/EAP contractor).

A.10. Value Based Initiatives

a. The Contractor shall implement episode or bundle based reimbursement strategies in a manner and on a timeline approved by BA. Contractor developed episodes or bundles, similar to the episodes implemented through the State's Payment Reform initiative, may be considered in lieu of the THCII episodes on a case-by-case basis, In Writing, as approved by BA.

(1) The Contractor's developed episodes or bundles shall include quality measures, include care from multiple providers, and utilize risk adjustment models as needed. The Contractor shall engage in provider education and reporting as applicable to the approved strategy. The Contractor shall provide annual reports summarizing the outcomes, savings, financial details for any provider rewards or risk payments for each approved and implemented Contractor developed episode or bundle reimbursement strategy.

b. If Contractor developed episodes or bundles are not available or approved, the Contractor shall implement the following current episodes of care as selected by BA, from the Tennessee Health Care Innovation Initiative (THCII) designed episode list.

i. Perinatal
ii. Total Joint Replacement (Hip and Knee)
iii. Percutaneous Coronary Intervention
iv. Cholecystectomy
v. Colonoscopy
vi. Esophagogastroduodenoscopy

vii. Bariatric
viii. Coronary Artery Bypass Graft
ix. Valve Replacement
x. Hysterectomy
xi. Knee Arthroscopy

(1) Implement key THCII episode design choices as directed by BA, including:
   i. Defining a principal accountable provider (PAP) to receive preview and performance reports and be eligible for rewards;
   ii. Adopting the definition of quality measures and their acceptable thresholds;
   iii. Including care from multiple providers in the episode;
   iv. Utilizing risk adjustment to reduce the impact of difference between patient age, morbidity, and other patient factors on the outcomes of the provider; and
   v. Implementing a financial model that includes contractual rewards to providers based on the cost and quality of the THCII episodes. The Contractor may set cost thresholds at their discretion. At the State's direction the financial model may include risk share payments by the principal accountable provider based upon cost thresholds set by the Contractor.

(2) The Contractor may customize THCII episode definitions as needed, In Writing, and approved by BA.

(3) Delivering preview and performance episode reports to providers detailing the provider's aggregate performance in meeting pre-defined cost and quality targets. The reports shall have a similar appearance and content as those designed by THCII on the following timeline;

   i. Preview reporting to all impacted providers without current contract amendments for any current episodes approved by BA beginning by January 2022;
   ii. Performance reporting to all impacted providers with current contract amendments for current episodes approved by BA, beginning by January 2022; and
   iii. Reporting for any future episodes shall follow specific episode implementation timelines as directed by BA.

(4) Engaging in provider education and communication so providers understand the THCII episode of care model and provider reports;
(5) Participating in any other THCII design processes and stakeholder processes as required by the State;
(6) For each THCII episode chosen by BA, the Contractor shall strongly encourage participation in episode based payments for all Network Providers who are expected to have at least 40 of these episodes of care across all of their commercial members in the upcoming performance period.
(7) The Contractor shall apply the episode model to any episode experienced by Plan Members by January 1, 2022.
(8) BA may grant exceptions, In Writing, to proposed THCII episode deadlines upon request from the Contractor as deemed appropriate by BA. BA's decisions on these issues are final and not subject to appeal.
(9) The Contractor shall deliver an annual THCII episodes report in a format determined by the State on or before October 31 (refer also to Contract Attachment C, Reporting Requirements).The annual report shall include financial details regarding total provider reward payments attributable to implemented THCII episodes for the previous year including provider name, provider group, episode type, date of episode, date of provider reward or risk payments, and plan/account. The annual report shall also include episode outcomes including

quality metric outcomes, number of episodes, total episode cost, average episode cost, number of providers per episode, and provider rewards and risk payments by episode.

c. The Contractor shall offer a PCMH or similar program, as approved by the State In Writing, with specific objectives of improving clinical outcomes, patient experience, overall cost control, and net savings across the continuum of services. The State recommends that the Contractor's program include NCQA PCMH recognition or similar. The Contractor shall disclose to the State the quality measures and necessary parameters for practices to receive enhanced payments. Prior to any enhanced payments the Contractor shall verify that practices have achieved the defined quality measures and additional necessary parameters, and shall report to the State performance outcomes and total payments earned.

d. PCMH or similar program initiatives shall include Collaborative Physical and Behavioral Health Care for all attributed patients. Collaborative care shall at a minimum include a behavioral health screening using an age appropriate nationally recognized tool, discussion with the provider if the screening is positive, and referral to a licensed behavioral health professional or coordinator for follow up. Behavioral health quality metrics shall be included in overall PCMH or similar program measurements and reported to the State in the overall PCMH performance reporting. The Contractor's program shall include NCQA PCMH Distinction in Behavioral Health Integration, URAC Measurement Based Care Distinction, or similar defined measurement parameters, as approved by the State In Writing.

e. The Contractor shall receive prior approval In Writing from the State for any Member attribution model and associated program payments in a PCMH, Accountable Care Organization, or any other similar model.

f. As directed by the State, the Contractor shall develop and/or implement a high performance or tiered network of providers and/or facilities as measured by their adherence to a standard set of evidence-based clinical protocols, cost efficiency (*e.g.*, cost per episode) and quality measures. The Contractor shall collaborate with and assist the State and its other contracted partners in the development of such standard protocols and measures, shall process claims, and implement any associated Member cost-sharing benefits or incentives (*e.g.*, lower rates of Coinsurance, Copayment in lieu of Coinsurance, waiver of or provision of lower Deductible amounts). This network may be geographically located in limited areas of the State and may be managed by another State contracted partner.

g. The Contractor may develop a high performance or tiered network of providers and/or facilities without State direction. Before implementing a high performance or tiered network, the Contractor shall submit its plan to the State for approval In Writing. The Contractor's plan shall include the information specified by the State, including at a minimum the (1) quality and cost efficiency measures that the Contractor will use to determine whether a provider or facility satisfies the criteria to participate in the network; and (2) proposed Member cost-sharing benefits or incentives for Members who receive covered benefits from high performance providers or facilities. The State may approve the Contractor's use of such Member incentives regardless of whether other TPAs for medical services have implemented such Member benefits or incentives.

h. The Contractor shall include in its provider network, transplant facilities that are Medicare-approved facilities. The Contractor shall only authorize and pay for organ transplants performed by a transplant program that is approved by Medicare for the applicable transplant (*e.g.*, heart/lung, heart-only, kidney-only). The Contractor may require additional criteria on their Network Providers over and above the requirements listed above. The Contractor shall establish transplant Centers of Excellence and the State may offer cost-sharing benefits or incentives for Members who receive transplants at a Contractor designated Center of Excellence.

i. The Contractor shall build by December 31, 2022 and maintain a network of Centers of Excellence for treatment or surgical interventions including but not limited to: bariatric surgery (COE use required), orthopedic surgery, oncology/cancer surgery, cardiology/cardiac surgery,

gene therapy, and maternity. The criteria for Centers of Excellence shall be developed by the Contractor and limited to facilities that adhere to the highest standards of patient safety and quality care. As directed by the State, the Contractor shall only authorize and pay for procedures performed at Centers of Excellence and/or shall provide incentives to Members to use Centers of Excellence for the specified services (including but not limited to lower Member cost sharing for procedures performed at such facilities). Additionally, the Contractor shall provide health navigators to direct Members to these facilities when medically appropriate.

j. The Contractor shall notify the State of any operations or plans to implement value based payments where such payments are differentiated based on quality and/or efficiency. Examples of such payments include, but are not limited to, provider incentive payments (e.g. pay for performance), enhanced or reduced reimbursement, capitation, and reference pricing. The Contactor shall not implement such value based payments without prior approval In Writing from the State.

k. The Contractor shall report descriptive information and data about its value based payments in sufficient detail to enable the State to make an approval determination as well as adequately monitor the Contractor's program and billings following approval. The information that may be requested shall include, but not be limited to, the following:

(1) The type(s) of arrangements, such as, withholds, bonus, capitation;
(2) The percent of any withhold or bonus the plan uses;
(3) The patient panel size and, if the plan uses pooling, the pooling method; and
(4) The projected financial impact to the plan as a result of the program; and
(5) If approved, semi-annual reporting (refer also to Contract Attachment C, Reporting Requirements) on the number of Members served, program specific outcomes, and financial impact of the program.

l. As directed by the State, the Contractor shall enter into direct contracts, on the State's behalf, for select Point Solutions that fill gaps in the State's current healthcare benefit offerings or help to solve specific challenges. The Contractor shall collaborate with the State during the direct contracting process in the development of fee schedules, standard protocols and measures, claims processing, and implement any associated Member cost-sharing benefits or incentives (*e.g.*, lower rates of Coinsurance, Copayment in lieu of Coinsurance, waiver of or provision of lower Deductible amounts, etc.). These Point Solutions shall not negatively impact the Contractor's risk of performance or trend guarantees and shall be excluded from guarantee calculations as necessary. Alternatively, should the Contractor enter into direct contracts for Point Solutions for their greater book of business, the Contractor shall offer, at the State's request, said Point Solutions to the State for implementation, at no additional administrative cost to the State above and beyond claims costs.

m. The Contractor shall offer to Members at least one national Telemedicine/Telehealth service benefit option that meets or exceeds T.C.A. and State of Tennessee Medical Board requirements and regulations and allows Members easy access to twenty-four seven (24/7) non-urgent acute care. The Contractor shall submit a quarterly telehealth utilization report that includes the number of enrollments/activations, number of encounters, top diagnosis, and top prescriptions (refer also to Contract Attachment C, Reporting Requirements).

n. The Contractor shall offer to Members at least one web based diabetes prevention program option based upon the Center for Disease Control's Diabetes Prevention Program including, but not limited to, Member and provider outreach and education. The Contractor shall be able to vary provider program payments based on Member participation and outcomes and must be billed as a claim. The Contractor shall submit a quarterly Diabetes Prevention Program outcomes report that includes the cumulative enrollees, enrollees by program stage, total weight loss, average weight loss by program stage, enrollees by weight loss range (below 0%, 0-3%, 3.01-5%, 5.01-7%, 7.01-10% and 10.01%+) and starting BMI (<25,25-29, 30-34, 35-39 and 40+) (refer also to Contract Attachment C, Reporting Requirements).

o. The State requests a mid-contract industry and innovation review and planning meeting. Said meeting shall occur at either the State offices or at the Contractor's offices and shall include Contractor executives and key leadership individuals with direct knowledge and influence of the Contractor's corporate vision and direction. Meeting date, agenda, and attendees shall be mutually developed, at a minimum, by the State program director and Contractor Account Executive.

A.11. Call Center

a. The Contractor shall operate a call center that uses a toll-free telephone number Dedicated to the Plans as the entry point for Members contacting the Contractor.

b. The Contractor's call center shall be open and staffed with trained personnel on the first day of annual enrollment.

c. The Contractor's call center and Dedicated member services representatives shall be located in the continental United States.

d. The Contractor may temporarily route calls to a different call center located in the continental United States for occasions related to weather, training, or similar situations. The Contractor shall notify the State of any such instances prior to the switch, or as soon as practical.

e. The Contractor's call center shall, at a minimum, accept calls Monday through Friday 7:00-5:00 CST, except on official State Holidays.

f. The Contractor's call center shall be equipped with TDD (Telecommunications Device for the Deaf) technology in order to serve the hearing impaired population.

g. During normal business hours the Contractor's call center shall have at least one member services representative on duty that is bilingual in English and Spanish. The Contractor shall provide oral interpretation services via a telephone interpretation service free of charge to callers with Limited English Proficiency.

h. The Contractor shall provide the State's ABCs with a special number or access code that they can use to have immediate access to a member services representative. The Contractor can satisfy this hotline requirement by expediting calls to this special number to the front of the general queue – or it may provide Dedicated staff to serve callers to this number.

i. The Contractor's call center shall meet each of the following performance standards (refer also to Contract Attachment D, SLA Scorecard):

(1) Daily ASA of thirty (30) seconds. After answering the call the Contractor may only put callers on hold in order to (a) make outbound calls as necessary or (b) to research a caller's issue.
(2) First Call Resolution of 85% as measured by one or more of the following methods: a Member post-call phone or web survey; an end of call script where the member service representative asks if the Member's issue has been resolved; a voice menu allowing the Member to indicate if this is the first call they've made to resolve their inquiry or problem; or another method prior approved by the state.
(3) Telephone Service Factor of 80-20, meaning 80% of calls are answered within 20 seconds.
(4) Open call/inquiry closure rate of 90% within five (5) Business Days.

j. The Contractor shall provide call center statistics to the State on a monthly basis beginning with the start of annual enrollment period (refer also to Attachment C, Reporting Requirements).

k. The Contractor's call center shall have call management systems and communications infrastructure that can manage the potential call volume and achieve the performance standards described in this Contract.

l. The Contractor's call management systems shall be scalable and flexible so they can be adapted as needed, within negotiated timeframes where applicable, in response to program, benefit, or enrollment changes.

m. The Contractor's call management systems shall be equipped with caller identification. In addition, the Contractor's call center shall adopt outbound caller identification for itself that is prior approved In Writing by the State.

n. The Contractor's call management systems shall provide greeting messaging when necessary. The Contractor may play canned music and/or messages prior approved by the State for the callers while they are on hold and shall play messages as directed by the State. The Contractor shall not play advertising or informational messages for callers while they are on hold unless prior approved In Writing by the State (or the State directs the Contractor to play certain messages). Additionally, the Contractor's systems shall provide a message that notifies callers that calls are being recorded and may be monitored for quality control purposes.

o. The Contractor's call management system shall record and index all calls such that the Contractor can easily retrieve recordings of individual calls based on the phone number of the caller, the caller's name, the date/time of the call, or the member services representative who handled the call. The Contractor shall be able to provide a full recording of each call upon the State's request, using only the Member's name or identifier to locate the call(s).

p. The Contractor's call management systems shall facilitate the processing of all calls received and assign incoming calls to available member services representatives in an efficient manner. The system shall transfer calls to other telephone lines as necessary and appropriate, including transfers to external call centers.

q. The Contractor may use an automated interactive voice response (IVR) system for managing inbound calls, provided that the caller always has the ability to leave the IVR system and wait in queue in order to speak directly with a live-voice member services representative during normal business hours rather than continue through additional prompts. The Contractor's decision tree and menu are subject to State review and prior written approval.

r. The Contractor shall inform callers of their likely wait times (based on real-time information, including call volume and member services representative availability) as they enter the queue. The Contractor shall also provide a "dial back" option that allows callers to receive a call back from the next available member services representative.

s. The Contractor shall have the ability to make outbound calls without interrupting the ability of callers to continue to access the call center.

t. The Contractor's system shall be able to record calls for monitoring and the Contractor shall, at the State's request, allow the State, or its authorized representative to review previously recorded calls from a remote location.

u. The call management system shall enable the logging of all calls, including but not limited to:

(1) the caller's identifying information (e.g., employee ID);
(2) the call date and time;
(3) the reason for the call (using a coding scheme);
(4) the member services representative that handled the call;
(5) the length of call; and
(6) the resolution of the call (including a resolution code) and, if unresolved, the action taken and follow up steps required.

v. Additionally, the call management systems shall maintain a history of correspondence and call transactions for performance management, quality management and audit purposes. This history shall contain the actual information, a date/time stamp that corresponds to when the transaction took place, the origin of the data management transaction (*e.g.*, the State and/or one of its authorized representatives or the Member), and the member services representative that processed the transaction. Related correspondence and calls shall be indexed and properly recorded such that they can be treated in reporting and analysis as part of a distinct transaction.

A.12. Claims Processing, Payment and Reconciliation

a. The Contractor shall process all claims for covered benefits provided to Members in strict accordance with the Plan Documents, applicable Contractor medical coverage policies and procedures, in compliance with all applicable state and federal laws, rules and regulations and the terms of this contract including, but not limited to, timely filing. The Contractor shall not modify the Plans' covered benefits or apply their standard book of business changes to benefits set up, procedures, or claims processing guidelines during the term of this Contract without the prior notification to and approval In Writing from the State. The Contractor shall retain records of all State approvals for benefit set up that do not align with the Contractor's standard book of business. The Contractor may be assessed liquidated damages as set forth in Attachment B, Liquidated Damages for any claims that are not processed according to State approved covered benefits.

b. The Contractor shall operate a claims management system that tracks accumulations toward Deductibles and out-of-pocket maximums, tracks Copayments and Coinsurance amounts and appropriately links claim history, enrollment information, member services, provider network, and utilization management information. This shall include the electronic exchange of all claims data to the HSA/FSA contractor as well as Member Deductible and maximum out-of-pocket accumulator data with the PBM, EAP/BHO, HSA/FSA, and any other State contractors as requested by the State.

c. Upon request by the State, the Contractor shall modify its systems and processes to reflect approved plan design changes, including but not limited to changes in covered benefits, scope of covered benefits, and cost-sharing, to the Plan(s) annually prior to the start of the benefit plan year or within sixty (60) days of notification by the State. Should said change(s) not be effective within sixty (60) days, the Contractor shall have until the effective date of the change to modify its systems and processes. Refer also to Contract Attachment B, Liquidated Damages.

d. The Contractor shall ensure that claims submitted by Network Providers are paperless for the Members. The Contractor's agreement with providers shall require Network Providers to submit claims directly to the Contractor.

e. The Contractor's claims management system shall be able to receive and process (*i.e.*, without subsequent data entry) physician and hospital claim submissions electronically.

f. The Contractor shall submit to the State, at least one (1) month prior Go-Live, a summary of its methodology for conducting internal claims audits, including audits to determine

claims payment and processing accuracy and claims payment turnaround. The State reserves the right to review the methodology and request changes, where appropriate. The Contractor shall notify the State In Writing at least thirty (30) days in advance of any significant changes to its methodology. The State reserves the right to review the change and request changes, where appropriate.

g. The Contractor shall confirm eligibility of each Member as claims are submitted, on the basis of the enrollment information provided by the State, which applies to the period during which the charges were incurred.

h. In concert with its claims payment cycle, the Contractor shall provide an electronic remittance advice (RA) to the provider indicating the disposition of every adjudicated claim submitted by providers. The remittance advice shall contain appropriate explanatory remarks related to payment or denial of each claim. If a claim is partially or totally denied due to insufficient information and/or documentation, then the remittance advice shall specify all such information and/or documentation. Providers that do not have the capability of receiving an RA electronically may have one mailed to them.

i. The Contractor shall process claims, either filed directly by Members and/or provider(s), in an accurate and timely manner and in accordance with the following claim processing standards.

(1) Unless otherwise specified by the State, the claims management system shall automatically adjudicate no less than eighty percent (80%) of Clean Claims, i.e., without recourse to manual or other calculation methods external to the system. The Contractor shall report Clean Claim automatic adjudication on a quarterly basis as outlined in Contract Attachment D, SLA Scorecard.

(2) The Contractor shall reimburse Network Providers within fourteen (14) calendar days for ninety-two percent (92%) of Clean Claims and within thirty (30) calendar days for ninety-eight percent (98%) of all claims (refer also to Contract Attachment B, Liquidated Damages).

(3) Financial accuracy shall be ninety-nine percent (99%) or higher. Financial accuracy shall be calculated and reported by taking the total benefit dollars paid in the population, minus the sum of the weighted absolute value of overpayments and underpayments, divided by the total dollars paid in the population. The Contractor shall report financial accuracy on a quarterly basis in a report format specified by the State (refer also to Contract Attachment B, Liquidated Damages and Attachment C, Reporting Requirements).

(4) Claims processing accuracy shall be ninety-six percent (96%) or higher (refer also to Contract Attachment B, Liquidated Damages).

(5) Claims payment accuracy shall be ninety-seven point five percent (97.5%) or higher (refer also to Contract Attachment B, Liquidated Damages).

(6) The Contractor shall complete ninety-five percent (95%) of all claim adjustments within seven (7) calendar days. The Contractor shall report claim adjustment processing on a quarterly basis as outlined in Contract Attachment D, SLA Scorecard.

(7) 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 and payment.

(8) The Contractor shall select at random, one hundred and seventy-five (175) incurred date claims and one hundred and seventy-five (175), different, paid date

claims and provide the selected claims data to the State on a quarterly basis (refer also to Contract Attachment C, Reporting Requirements). The State will analyze the claims data provided to validate the Contractor's compliance with standards 2, 4, and 5 above. Should the State identify a Contractor deficiency, the State shall provide substantiation of said deficiency to the Contractor who shall have thirty (30) days to provide substantiation to the contrary. Should the Contractor be unable to successfully provide substantiation of compliance with the above claim processing standards, the Contractor may be assessed liquidated damages as set forth in Contract Attachment B, Liquidated Damages.

j. The Contractor's claims management system shall retain claim history on-line for at least three (3) years and it must be made available either online or upon request. This does not limit the Contractor's obligations to retain all records in accordance with Contract Section D.11, Records.

k. The Contractor shall test the accuracy of automated features of the claims management system (*e.g.*, Deductible calculation) at least annually as part of its internal audit program policies and procedures.

l. At the State's request, the Contractor shall load Plan claims data into an all payer claims database.

m. The Contractor shall use a clinical edit software program that automatically evaluates all claims for medical bills involving the use of current ICD and CPT/HCPCS codes. Clinical claim review software shall be updated no less than once every year, and all changes and new codes shall be incorporated by the Contractor within thirty (30) days of the change becoming effective.

n. The Contractor's claims management system shall automatically price network claims using current Network Provider rate information. The claims management system shall store Network Provider information to determine provider status and reimbursement for claims from Network Providers. The Contractor shall provide a copy of their standards for updating Network Provider rate information in their claims management system at least 30 days prior to Go-Live. Network Provider rate information shall be updated in the claims management system according to the Contractor's documented standards.

o. The Contractor's member services representatives shall have access to claims management and other systems as necessary to respond to inquiries from Members.

p. Explanation of Benefits (EOB)

(1) The Contractor shall generate and mail an EOB to the Member each time the Contractor processes a claim from a provider where the Deductible, Copayment, Coinsurance, etc. is greater than zero, unless specifically requested by a Member. The Contractor shall mail the EOB within five (5) Business Days of processing the claim. The EOB format and text shall be prior approved In Writing by the State and shall include, but not be limited to, the date the Contractor received the claim, the date the Contractor adjudicated the claim, the claim number, identification number of the head-of-contract, the patient name, the date of service, type of service furnished, the provider name, the Contractor's contact information, submitted charges, total amount paid by the plan, the amount paid by another insurance carrier, total amount owed by the Member by cost-sharing category (Deductible, Copayment, Coinsurance, etc.), any non-covered amount, the out-of-pocket amounts paid for the year, how to file an appeal, adjustments or corrections that affect a Member's out-of-pocket costs, and any other information legally required. The Contractor may substitute electronic EOB statements if requested by the Member.

(2) The Contractor shall also generate and mail an EOB to the Member each time the Contractor processes a claim submitted by the Member where the Deductible, Copayment, Coinsurance, etc. is greater than zero, unless specifically requested by a Member. The Contractor shall mail the EOB within five (5) Business Days of processing the claim. The EOB format and text shall be prior approved In Writing by the State and shall include information similar to the EOB for provider-submitted claims but tailored to Member-submitted claims. The Contractor may substitute electronic EOB statements if requested by the Member.

q. If a Member receives a covered benefit from a Network Provider, the Network Provider's contract rate shall be used to determine the Member's Deductible (if applicable) and any Copayment or Coinsurance amount and the Member shall not be responsible for payment in excess of that amount. In addition, if a Member receives a medical service from a Network Provider but the claim for the service is denied as ineligible for payment (*e.g.*, the service exceeded the applicable service limitation, was not medically necessary, was experimental or investigational, or the service was subject to PA and was not approved by the Contractor) the Member shall not be responsible for payment to the provider unless the Network Provider can provide a copy of an advance beneficiary notice (waiver) for the specific services rendered and the date of service, signed by the Member prior to the service by the Member prior to the service being rendered.

r. The Contractor shall only pay claims that are for covered benefits provided to eligible Members and provided in accordance with the Contractor's medical policies, PA, utilization management, other applicable requirements, and with the Plan Documents.

s. The Contractor shall not pay for services that result from a referral prohibited by Section 1877 of the Social Security Act (Limitation on Certain Physician Referrals).

t. The Contractor shall not knowingly pay for preventable events and conditions, *e.g.*, hospital-acquired conditions and preventable surgical errors that are identified as non-payable by Medicare. In addition, as directed by the State, the Contractor shall not pay for other preventable events and conditions that are identified as non-payable by other federal or state payers. At the State's request, the Contractor shall provide a report of these Denied Claims and the avoided charges to the State. If it is later determined that a payment has been made for a preventable event or condition, the Contractor will reverse the payment or recoup the payment from the provider.

u. The Contractor shall pay claims for services from Out-Of-Network Providers submitted by Members by directly reimbursing the provider. However, if the Member has already paid said claim, then the Contractor shall reimburse the Member directly. In either case the Contractor shall send the Member an EOB.

v. The Contractor shall pass directly to the State the payment terms that the Contractor has negotiated with providers. The Contractor shall not receive any differential between the provider contract rate and the payment funded by the State; the Contractor shall ensure that the State and the Member receives the full benefit of any provider payment terms, including, but not limited to, provider fee schedules, contract rates, other payment arrangements, discounts, rebates, refunds, or credits negotiated by the Contractor. All special pricing considerations and financial incentives shall accrue to the State and Plan Members.

w. The Contractor shall remit to the State no less frequently than quarterly a check for 100% of all rebates accrued which were obtained on behalf of the State, by the Contractor (including rebate aggregators or any similar contracted entities), due to the use of medical services, devices, and pharmaceuticals (including Specialty Drugs) by Members of the Plans. A report shall accompany each check containing a breakout by Plan Group fund (i.e. State Actives, State Retirees, etc.) and further broken down by service or

product name and the appropriate codes to identify the service or product (e.g. NDC, NDC plus the appropriate HCPCS Level II code, J-codes, etc.). Refer also to Contract Attachment C, Reporting Requirements. Contractor shall include for each breakout the total amount invoiced to the manufacturer, the total amount collected on behalf of the state, and the amount being paid to the state, as well as the calendar quarter to which the various Rebate amounts are attributable. The Contractor shall not enter into any agreement with a pharmaceutical manufacturer for Rebates with the impact to reduce or otherwise circumvent monies received from pharmaceutical manufacturers as being considered Rebates. The State reserves the right to audit the rebate payments in accordance with A.24.a to ensure 100% of all rebates accrued were paid to the State correctly.

x. The Contractor shall ensure that any payments funded by the State are accurate and in compliance with the terms of this Contract; agreements between the Contractor and providers; and state and federal laws and regulations.

y. The State shall determine all policies and benefits related to the Plans and shall have the sole responsibility for and authority to clarify and/or revise the benefits available under the Plans. Should the Contractor have a question on policy determinations, benefits, or operating guidelines required for proper performance of the Contractor's responsibilities, the Contractor shall request a determination from the State In Writing. The State will then respond In Writing making a determination within thirty (30) days. The Contractor shall then act in accordance with such policy determinations and/or operating guidelines.

z. The Contractor understands that the Plans cannot and do not cover all medical situations. In a case where the benefits are not referenced in the Plan Documents or are not clear, the Contractor shall comply with any applicable policy issued by the State to interpret the Plan Documents. If the benefits are not referenced in any policy or are not clear, the Contractor shall utilize its standard policies in adjudicating claims, and the Contractor shall advise the State In Writing, as to the difference along with the Contractor's recommendation. Such matters as determined by the State to have a significant impact on administration of plan benefits shall be resolved by the State.

aa. The Contractor shall identify and pursue claims that may be subject to coordination of benefits (COB) in accordance with the regulations promulgated by the Plan Document and Tennessee Department of Commerce and Insurance, Chapter 0780-1-53 Tenn. Comp. R. & Regs. The Contractor shall provide a report of said activities to the State upon request. The Contractor shall provide a weekly report of necessary updates to Member eligibility records regarding coordination of benefits and other payer coverage (refer also to Contract Attachment C, Reporting Requirements).

bb. The Contractor shall notify the State, in a weekly report, the receipt of any notices from Medicare that Medicare may have made primary payments for services when it should have been the secondary payer for the timeframe from Go-Live through the claims runout period (a Medicare Secondary Payer demand letter). Refer also to Contract Section A.12.pp. and Contract Attachment C, Reporting Requirements. The Contractor shall resolve issues as to whether Medicare is the primary or secondary payer within thirty-one (31) days of receiving the demand letter.

cc. The Contractor shall implement a process to carry out recoveries, including but not limited to subrogation, and report recovery activities to the State. The Contractor shall submit to the State a monthly recoveries report of all recoveries including but not limited to subrogation in a format prior approved by the State (refer also to Contract Attachment C, Reporting Requirements).

dd. The Contractor shall determine whether eligible expenses are medically necessary.

ee. The Contractor shall have a process in place based on the most appropriate up to date clinical information for determining those procedures and services that are considered experimental/investigational. Unless otherwise directed by the State, the Contractor shall submit to the State, at least one (1) month prior to Go-Live, detailed information on the Contractor's process for determining experimental/investigational procedures and services. The Contractor shall notify the State, In Writing, within thirty (30) days of any significant changes to its process.

ff. Unless otherwise directed by the State, the Contractor shall respond to all claims/data requests from the State within seventy-two (72) hours of receiving the request and shall present the information in the format requested by the State.

gg. Reconciliation

(1) The Contractor shall submit claims and bank draft reports to the State in sufficient detail for the State to record and reconcile claims. The format of the claims reports shall include at a minimum: each bank draft amount; date of bank draft; number, date range, and amount of associated claims adjudicated per draft; account number; fund code; any non-claim based payments which shall be separate and identified; etc. The report format shall be prior approved by the State and the frequency of report delivery shall match the frequency of the Contractor's bank drafts (refer also to Contract Attachment C, Reporting Requirements).

(2) The Contractor shall submit to the State a monthly reconcilliation report which shall include the total paid amount for all claims by agency (State/Higher Ed, LEA, LGA), Active or Retiree, and plan in a format prior approved by the State (refer also to Contract Attachment C, Reporting Requirements).

(3) The Contractor shall reconcile, within ten (10) Business Days of receipt, payment information provided by the State. Upon identification of any discrepancies, the Contractor shall immediately advise the State.

(4) The Contractor shall provide authorized State users with access to its internal client financial reporting system for use in the State's reconciliation process. The financial reporting system shall provide State users with the ability to access claim level detail.

hh. The Contractor's provider agreements shall include the maximum recoupment periods permitted under Tenn. Code Ann. § 56-7-110.

ii. For the payment of all claims under this Contract, the Contractor shall issue payments in the form of checks and/or Automated Clearing House (ACH) electronic funds transfer against the Contractor's own bank account. The Contractor shall maintain security and quality controls over the design, printing and mailing of checks, as well as any fraud prevention feature of checks.

jj. The State will only pay for approved and correctly Paid Claims, not for rejected, reversed, duplicate claims, claims processed but not paid, or claims paid in error.

kk. The Contractor shall reimburse the State for one hundred percent (100%) of claims paid in error. If the Contractor is unable to withhold the amount from the provider's next payment then the Contractor shall reimburse the State within thirty (30) days of identification of the overpayment, or within a time frame agreed to by the State.

ll. The Contractor shall provide a list of Denied Claims every quarter for the previous quarter (refer also to Contract Attachment C, Reporting Requirements). The State shall conduct a review of a random sample of twenty-five (25) Denied Claims per quarter and shall send said claims to the Contractor for review and comment. The Contractor shall review the reason for the denial and confirm that the claim was appropriately denied within thirty (30)

days of receipt. Any claims found to be inappropriately denied shall be reprocessed for payment by the Contractor.

mm. The State shall conduct a monthly review of Pended Claims. The Contractor shall provide a current list of Pended Claims every month including the current status of prior and newly Pended Claims and the top reasons claims are pended (refer also to Contract Attachment C, Reporting Requirements).

nn. The Contractor shall provide a quarterly incurred but not reported (IBNR) report of monthly claims and enrollment data by the following splits for the forty-eight (48) months leading up to and including the most recent month to the State actuarial contractor. Claims should be summarized by both the month of service and payment (standard lag/triangle data summary) for the following:

(1) Active/Retired (claims and enrollment),
(2) Medical/Pharmacy (claims only), and
(3) State/Local Education/Local Government (claims and enrollment).

oo. The Contractor shall issue all related U.S. Internal Revenue Service (IRS) Form 1099 reports, submit required 1099 information directly to the IRS utilizing the Contractor's tax ID number, and shall maintain responsibility in matters relating to such information provided to payees and to the IRS, including the payment of any penalties or fees related to such 1099 reporting.

pp. Upon conclusion of the service delivery period (1/1/22-12/31/27) of this Contract, or in the event of its termination or cancellation for any reason, the Contractor shall be responsible for the processing of all claims incurred for medical services rendered and medical supplies purchased during the service delivery period of this Contract as well as provider reimbursement or recoupment attributable to claims incurred during the service delivery period of this Contract with no additional administrative cost to the State. The claims runout period shall extend through the final day of the eighteenth (18th) month following 12/31/27. In addition, in the event of termination of this Contract prior to 12/31/27, the Contractor shall continue to provide and pay claims for services to any Member who is hospitalized on the effective date of termination. Said coverage shall discontinue when the Member is discharged from the hospital.

qq. The Contractor shall require Network Providers submitting a claim with a miscellaneous pharmaceutical HCPCS code to include the name of the drug and the National Drug Code (NDC) and the number of units on the associated professional claim form (HCFA 1500) or facility claim form (UB92).

A.13. Member Communications/Materials

a. The Contractor, in collaboration with the State, shall develop a detailed written annual enrollment Member engagement plan for Member education at least two (2) months prior to annual enrollment. This plan shall include the overall goals, methods, tools, technology, and timelines for Member engagement during implementation and annual enrollment including but not limited to benefit fair materials, ABC materials, enrollment emails, Splash Page (see Contract Section A.15), and Member welcome kits and ID cards (see Contract Section A.14). Going forward, the Contractor shall update this plan on an annual basis, at least two (2) months prior to annual enrollment, to reflect any changes in marketing strategy and updated methods, tools or technology to engage with Members.

b. The Contractor, in collaboration with the State, shall develop an annual detailed written marketing and communications plan for ongoing Member education by November 30. This plan shall include the overall goals, methods, tools, technology, and timelines for

Member engagement including any changes in marketing strategy and updated methods. Contractor's marketing plan will reflect a thoughtful, proactive approach to encourage Member enrollment and to drive engagement and utilization of applicable services and programs such as diabetes prevention program, telehealth, Contractor sponsored preventive screening opportunities, and closing gaps in care. The Contractor is encouraged to relay resources they have that will support marketing and communications. All marketing and communication plan updates shall be approved In Writing by the State.

(1) The Contractor shall collaborate with other contractors to generally promote benefits, wellness program initiatives, annual exams, preventive screenings, H&W Center, EAP/BHO, and other health, wellness and benefit programs, if applicable.

(2) The Contractor will provide a semi-annual analytics report of marketing and communications efforts that could include email, website or other communications statistics. Contractor shall use the State's template or the Contractor's template with prior approval In Writing by the State (refer also to Contract Attachment C, Reporting Requirements).

(3) The Contractor covenants that all materials distributed and prepared or produced by the Contractor shall be accurate in all material respects.

c. The Contractor shall, in consultation with the State, develop and disseminate Member information and communication materials. All materials must have approval In Writing by the State prior to distribution (refer also to Attachment D, Service Level Agreement). Contractor shall ensure that all Member materials and other communications meet any state or federal regulatory compliance (e.g., Civil Rights Compliance), if applicable. The Contractor shall develop all materials in conformance with the style, formatting and other related standards developed by the State and its marketing staff.

(1) Materials could include, but are not limited to, Member handbooks, provider directories, identification (ID) cards, welcome packets, letters, brochures, fliers, webinars, website copy, website images, mobile app and app content, social media content, PowerPoints, training materials, marketing materials specific to Plan or agency and videos.

(2) Marketing/segmenting: Contractor may offer or suggest marketing and communications based on segmentation of population (e.g., demographics, geography, etc.). Contractor may provide data to address paths and barriers to engagement.

(3) The Contractor shall, upon request by the State, personalize materials and digital communications.

(4) Contractor shall provide, upon request by the State, marketing and communications samples of how they introduce Plan options to Members and continually drive engagement and utilization of preferred services.

(5) The Contractor shall use graphics to communicate key messages to populations with limited literacy, limited health plan literacy or limited English proficiency. The Contractor shall also prominently display the call center's telephone number in large, bolded typeface and hours of operation on all materials.

(6) The Contractor shall provide text and graphics, if applicable, for the State's communication to Members.

(7) As part of its submission to the State, the Contractor in consultation with the State, shall specify how the materials will be distributed.

d. On an annual basis, at least two (2) months prior to the State's annual enrollment period, the Contractor shall provide to the State, in electronic format, any annual enrollment material included in the annual enrollment plan that may be helpful to potential Members. Items may include, but not be limited to, informational fliers, program specific information, toll-free call center number, website address, website logon information, a confidentiality statement, procedures for accessing services, and other pertinent updates, changes and/or materials. Annual enrollment materials (not including Member handbooks) shall be

finalized (including State review and sign-off) and ready for distribution one (1) month prior to the first day of annual enrollment or as otherwise agreed upon by the State.

e. In addition to the Member information and communications referenced above in Contract Section A.13.c., the Contractor shall assist the State, if requested, in the education and dissemination of information regarding the program. This assistance may include but not be limited to:
   (1) Written information;
   (2) Audio/video and webinar presentations;
   (3) Member and Agency Outreach: With notification In Writing to the State, attendance at meetings, workshops, benefits fairs, marketing events and conferences (approximately 60-70 annually).
      i. Educating State staff, ABCs, Members and other persons on Contractor's administrative and benefits procedures. Specifically, when a new agency joins the Plan, Contractor may be asked to attend onsite enrollment and benefits educational events.
      ii. Educating Members and ABCs could include targeted agency outreach and partnering with other state departments on outreach efforts across the state on benefit implementation, engagement and education.
      iii. Any on-site visits to agencies, marketing or other state department co-marketing efforts shall require prior notification In Writing to the State. The State also reserves the right to request Contractor's attendance at specific events.

f. Unless otherwise specified, the Contractor shall be responsible for all costs related to the design, development, printing, distribution, mailing (if applicable) and revision of all materials that are required to be produced under the terms of this contract.

g. The Contractor shall use First Class Mail for all mailings, unless otherwise directed or unless otherwise approved by the State In Writing. With prior approval, the State may approve bulk or alternative rates.

h. Contractor shall comply with the Federal Register Nondiscrimination in Health Programs and Activities (81 FR 31375, 45 CFR 92).

i. The Contractor shall provide the State with draft versions of all communications materials and letters at least fourteen (14) Business Days prior to planned printing, assembly, and/or distribution (including web posting). The Contractor shall not distribute any materials until the State issues approval In Writing to the Contractor for the respective materials (refer also to Attachment D, Service Level Agreement). The State has and retains the ability to edit and customize all communication pieces distributed by the Contractor, including the right to require that the State branding "ParTNers for Health" logo be included on any Member letters or correspondence. The Contractor shall ensure communications are specific to the Plan design and not simply a rebranding/repackaging of standard book-of-business materials or communications unless it is to remain in compliance with other regulatory requirements.

j. The Contractor shall work in conjunction with the State's staff to ensure continuity of branding across all program and materials, fliers (including digital), mailings, emails, website, apps, social media and any other communications information, tools, communication methods, and resources. This branding shall include, but is not limited to, use of the ParTNers for Health logo, color scheme and applicable taglines. All uses of these branding elements shall be subject to prior approval In Writing by the State. All marketing and communications materials, including contact information for any Members, shall become property of the State.

k. The Contractor shall have the exclusive responsibility to write, edit and arrange for clearance of materials (such as securing full time use of a stock photograph for perpetuity) for any and all marketing and communication materials.

l. The Contractor shall distribute materials that are culturally sensitive and professional in content, appearance and design with prior approval In Writing by the State.

m. The Contractor shall provide electronic templates of all finalized materials in a format that the State can easily alter, edit, revise and update.

n. Unless otherwise prior approved In Writing by the State, the Contractor shall design all marketing and communication materials at a sixth (6.0) grade reading level or lower using the Flesch-Kincaid Index, or a comparable product. The Contractor shall evaluate materials using the entire text of the materials (except return addresses). When submitting draft materials to the State for approval, the Contractor shall provide a certification of the reading level of each piece of material.

o. At the State's request and upon sufficient notice, the Contractor shall notify Members, In Writing, of any benefit, Plan or program changes no less than thirty (30) Business Days prior to the implementation of the change.

p. Unless otherwise directed by the State, the Contractor shall print and distribute any mass mailings developed by the State within fourteen (14) Business Days of receiving the language/copy from the State.

q. The Contractor shall ensure that up-to-date versions of all printed Member marketing and communication materials can be downloaded from the Splash Page. The Contractor shall provide an electronic copy of all marketing and communication materials, including provider directories, at the State's request to the State for posting on the State's website.

r. The Contractor shall update web-based versions of all materials as Plan changes are made and correct errors. The Contractor shall update web-based versions at the request of the State, within five (5) Business Days. New Plan year information must be added no later than one (1) month prior to annual enrollment.

s. Unless approved in advance and In Writing by the State, the Contractor shall not distribute any promotional materials or gifts to employees or Members, even if such gifts are of a deminimus value (e.g., magnets, pens, etc.).

t. Postage and production costs incurred by the Contractor, which are the direct result of communications requested by the State for benefit Plan changes outside of annual enrollment, shall be treated as pass-through costs and shall include substantiating documentation, including a line-item description of the postage and production costs incurred by the Contractor. The State shall pay the postage, printing and production costs of such mailings pursuant to Contract Section C.3. However, if a mistake is the result of the Contractor's error and is not corrected prior to printing or distribution, the Contractor shall pay the postage, printing and production costs for these communications. The Contractor shall produce and distribute corrected versions of individual materials at the State's discretion within ten (10) Business Days.

A.14. Member Handbooks, Welcome Kits, and ID Cards

a. The Contractor, following review and approval In Writing by the State, shall write, update, print and distribute, upon the State's request, Member handbooks and shall maintain an up-to-date version of the Member handbook on the State's Splash Page and website (see Contract Section A.15).

b. The Contractor shall mail a Member handbook, with a cover letter if requested by the State, no later than ten (10) Business Days from receipt of a Member's request for a copy. The Contractor shall, at a Member's request, mail a copy of the current provider directory to the Member within ten (10) Business Days of receiving the Member's request to have a copy.

c. The Member handbook shall include information on each of the Plan options available to Members and new employees for the effective plan year. Handbooks shall be reviewed an updated each year no later than two (2) months prior to the start of the next plan year. Handbooks shall include, but are not limited to, detailed benefits and excluded services and procedures; detailed cost-sharing requirements and out-of-pocket maximums for each benefit option; describe additional features specific to any of the benefit options; describe procedures for accessing services, including use of network and out-of-Network Providers and utilization management; describe appeal procedures; include information specified by the State regarding pharmacy benefits, behavioral health benefits, and population health; and provide other information helpful to Members.

d. Unless otherwise directed by the State, the Contractor shall mail ninety-five percent (95%) of annual welcome kits to Members no later than fourteen (14) Business Days prior to Go-Live and thereafter, fourteen (14) Business Days prior to the start of each benefit year. The welcome kit shall include but is not limited to: a welcome letter, an ID card (if applicable and can be mailed separately), a postcard to request a printed copy of the Member handbook and/or provider directory, a URL to the customized Splash Page maintained by the Contractor, the Contractor's toll-free member services number, informational program fliers, and general website login information. (Refer also to Attachment B, Liquidated Damages)

e. As a new Member(s) join the program, or if a Member transitions from one Plan option to another during the plan year, they shall receive a welcome kit and ID card (can be mailed separately) no later than ten (10) Business Days from the date of initial enrollment passed to the Contractor on the enrollment file. (Refer also to Attachment D, SLA Scorecard.)

f. Upon the State's request, the Contractor shall provide Member handbooks to specified parties, e.g., ABCs, within fourteen (14) days Business Days of the State's request to provide copies. The number of Member handbooks, provider directories, fliers and other relevant information to be printed shall be in sufficient quantities for distribution by the Contractor to the State's Members and ABCs, plus a quantity of handbooks and brochures as requested by the State for distribution to potential new Members, unless otherwise directed In Writing by the State.

g. The Contractor shall provide enrolled Members with ID cards and shall establish a process that allows Members to request replacement or duplicate cards by phone, online, mobile app (if applicable) and/or other possible future methods or technology upon request. ID cards shall be mailed to Members no later than ten (10) Business Days from receipt of the Member's request for a replacement card.

h. The cost of creating and mailing ID cards are the responsibility of the Contractor.

i. Ninety-five percent (95%) of initial Member ID cards must be mailed to all Members no later than fourteen (14) Business Days prior to Go-Live as long as all implementation milestones have been met. (Refer also to Attachment B, Liquidated Damages)

j. The ID card shall include the State's "ParTNers for Health" color logo, on the top front of the card, as directed by the State and the Contractor's logo may appear on the front in a corner.

(1) The words "Administered by CONTRACTOR NAME: may appear beneath this in a smaller font size.

(2) The front of the card shall also include the following information: Member name, Member number, Member Plan Group name and/or number; benefit option (e.g., Premier PPO), network name (if applicable), and select cost sharing amounts, as requested.

(3) The back of the card shall include the following information: disclaimers regarding PA, card effective date (may appear on the front of the card), the Contractor's member services phone number and hours of operation, and the phone number for other State contractors including the PBM, EAP/BHO, and PH/W. The State has final approval of the ID card appearance and language/copy.

(4) ID cards shall contain a unique Member number for each Member, which shall be the employee's unique Edison ID, the full eight (8) digit number (with leading zeroes), provided on the monthly enrollment file. Such identifier shall NOT be the Member's federal Social Security Number. Contractor may add additional identifiers if prior approved by the State In Writing.

k. As directed by the State, the Contractor shall re-issue ID cards to reflect approved Plan design changes, included but not limited to, changes in cost sharing, within the timeframe specified by the State

A.15. Splash Page, Contractor Website, and Mobile Application

a. The Contractor shall maintain a Splash Page Dedicated to and customized to the State, containing program information specific to the Plan membership, which does not require a Member to log in. The design of the Splash Page, inclusive of the site map, page layout, color/font scheme and branding, static content and any documents which can be accessed via, or downloaded from, the Splash Page must be prior approved In Writing by the State. The Contractor shall obtain prior approval In Writing from the State for any links from the site to an external website/portal or webpage.

b. The Splash Page shall at a minimum contain the following information or a link to the information:

(1) Contractor member services phone number and hours;
(2) Plan benefits;
(3) Member handbook(s);
(4) Provider directory as a PDF (if requested by the State);
(5) Up-to-date searchable internet-based directory (specific to the Plan if applicable);
(6) Member tools and information;
(7) Information on how to understand an EOB, including a sample;
(8) Provide links to other State contractors' websites; and
(9) Other information as requested by the State.

c. The Contractor shall link the Splash Page to the the State website, other State contractor websites, microsites, content or other web or mobile device enabled video/multimedia tools apps, methods or technology as determined by the State that are useful or applicable for Members (State-approved tools from other approved contractors).

d. The Splash Page shall have the capability to host streamed content (both audio and video) from other contractors including video/multimedia tools as determined by the State if useful and applicable to Members.

e. Contractor shall have a link to the Contractor's website with a Member log-in portal on the Splash Page so Members can view Member-specific documents, including but not limited to claims information, Plan documents and other material pertaining to benefits.

f. The Contractor's website for this program shall be enabled for mobile devices, mobile app or by other methods that may apply. The website shall at a minimum contain:

(1) Member specific benefits;
(2) Member claims history and information on how to understand an EOB with a sample;
(3) Have an intuitive user interface, including a frequently asked questions (FAQs) section and other resources;
(4) Online secure messaging or chat capabilities to answer questions from Members;
(5) Access to temporary Member ID cards;
(6) Any applicable Member forms (e.g., claim forms, appeal forms, etc.);
(7) Provide links to other State contractors' websites;
(8) Include up-to-date information on a Member's out-of-pocket costs;
(9) Include up-to-date information on a Member's HSA and FSA balance (if applicable and requested by the State);
(10) Contain Contractor medical coverage policies;
(11) Contain condition specific information to educate Members about their diagnosis or upcoming treatments and procedures;
(12) Contain information to educate Members about unneeded tests and procedures (e.g., information from Choosing Wisely).

g. The Contractor's website shall also contain consumer cost transparency and quality tools which allow Members to research the price and quality of health care services. At a minimum the tools must:
(1) Allow Members to search and compare information easily, using a variety of parameters including but not limited to provider, facility, location, service, quality measures, procedure, price and condition;
(2) Present price information based on how a current claim would process based on the Member's benefits, and shall not be limited to historical claims data. Transparency tools should be updated at least quarterly to ensure most accurate pricing is presented;
(3) Display prices for a total episode of care (e.g., pregnancy through delivery) with cost categories (provider, facility, ancillary, etc.) so Members understand the total cost for that episode and their share of cost;
(4) Alert Members about opportunities for savings;
(5) Provide quality information based on outcome measures when available; otherwise it should be based on nationally-endorsed, consensus-based process measures proven to lead to improved clinical outcomes (e.g., CMS quality measures, Leapfrog quality indicators, etc.);
(6) Allow for a Member shared savings payment, as directed by the State;
(7) Include at a minimum, the following information in a quarterly transparency tool report (see Contract Attachment C, Reporting Requirements):

i. Track the number of Members accessing the transparency tool;
ii. Track the number of Members who are return users of the tool;
iii. Track the most frequent cost and quality searches made by Members;
iv. Identify those Members who searched for a service within ninety (90) Calendar days of purchasing such service; and
v. If implemented, additional shared savings payment program reporting measures shall be included, as directed by the State

h. The Splash Page and Contractor website shall be fully operational with the exception of Member data/PHI at least thirty (30) days prior to the first day of annual enrollment, including annual benefit updates pertinent to the upcoming plan year. Refer also to Contract Attachment B, Liquidated Damages.

i. The Contractor shall submit the text and screenshots of the Splash Page, grant the State access to the customized development Splash Page, and provide log-in credentials for the Contractor's website for this program to the State for review and approval at least two (2) months prior to annual enrollment.

j. Unless otherwise approved by the State, the Contractor shall update content and/or documents posted to the Splash Page or website within five (5) Business Days of the State's prior approval of changes to said content and/or documents.

k. The Contractor shall ensure that all up-to-date versions of all printed materials can be downloaded from the Splash Page or accessible via a mobile device, or other method, if applicable.

l. Contractor shall obtain prior approval In Writing from the State for any links from the site to a non-governmental website or webpage.

m. The Contractor shall host the website on a non-governmental server, which shall be located within the United States. The contractor shall have adequate server capacity and infrastructure to support the likely volume of traffic from Members without disruption or delay.

n. The Contractor shall obtain and cover the cost of the domain name for the Contractor's Splash Page. The Splash Page URL must be prior approved by the State In Writing.

o. To ensure accessibility among persons with a disability, the Contractor's Splash Page and the Contractor's website shall be in compliance with Section 508. If the Contractor posts any video content it shall include closed captioning option and/or include text scripting to comply with Section 508 for these products.

p. In order to ensure accuracy, the internet-based, searchable provider directory shall include provider name, specialty, address and phone number and shall be updated within 10 (ten) Business Days of a provider's network effective or termination date and whether or not the provider is accepting Members as new patients. The Contractor shall provide the internet-based provider directory on its Contractor website and a link on the Splash Page at least thirty (30) days prior to the first date of annual enrollment.

q. The Contractor may include a mobile application for use by Members with prior approval In Writing by the State. The Contractor must agree to and adhere to all security measures as it relates to Member data. The Contractor must provide a secure web-based application that requires only a web-browser and an Internet connection.

r. At the State's request, the Contractor's mobile application(s) shall be linked with other web applications to allow for seamless data linkage (this may include, but is not limited to, single sign-on) of Member information including the ability for Members to, as applicable, access claims and EOB information, view ID cards, upload information (through a mobile device), or link to other technology or information that is helpful to the Member. The Contractor must work with any and all State contractors on data updates and shall send and/or receive files as needed.

s. The Contractor agrees that the State shall have the authority to request revisions to the Contractor's online Terms and Conditions or Online Service Agreement at any time and that the State shall be provided with a copy of any Terms and Conditions that a Member must consent to in order to be provided with online account access. If the Contractor revises the online Terms and Conditions or Online Service Agreement, the Contractor agrees to provide the State with a copy of the proposed changes at least sixty (60) Business Days prior to the new effective date, and will allow the State to make revisions.

A.16. <u>Pharmacy</u>

a. The State contracts with a PBM for the purpose of providing most outpatient pharmacy services. However, the PBM is not the exclusive provider of all outpatient pharmacy

products. Rather, the Contractor shall have responsibility for paying claims for certain office-administered immunizations (*e.g.*, for seasonal flu, pneumococcal, shingles, etc.), injectables, infusion therapy, and other Specialty Drugs as directed by the State. The Contractor shall evaluate and transition appropriate outpatient specialty pharmaceuticals to the most clinically appropriate cost effective site of care such as physician offices or home health from hospital settings which tend to have higher costs.

b. The Contractor shall pay for allowable, medically-necessary office visits for Members who bring pharmacy-supplied Specialty Drugs to a provider for administration.

c. The Contractor shall ensure that its Network Providers comply with the applicable drug utilization review and PA requirements for office-administered, office-supplied Specialty Drugs. The Contractor shall further ensure that its Network Providers do not bill Members for any claims that the Contractor rejects because of the provider's failure to comply with such requirements. Additionally, the Contractor shall provide its Network Providers with sufficient training, references and educational materials to ensure provider compliance.

d. Except as provided in Contract Section A.16.a., above, the Contractor is not responsible for the provision or payment of outpatient pharmacy services. However, the Contractor is responsible for coordinating with the PBM and the State as necessary to ensure that Members receive appropriate pharmacy services. Coordination by the Contractor shall include the following:

(1) Inclusion of pharmacy benefit information in its member handbook (see Contract Section A.14.c.), including the toll-free telephone number for the PBM.
(2) Inclusion of the PBM's telephone number, on the back of the Member identification card (see Contract Section A.14.j.).
(3) Inclusion of pharmacy benefits information in the Contractor's annual enrollment materials for distribution to Members, as requested and approved by the State. Such materials shall include network lists, website information, toll-free member services number, policies and procedures, confidentiality statement, hyperlinks to the State and other contractors (as directed by the State), and other updates and/or changes that may be helpful to Members. At the state's request and direction, the Contractor shall also include in its annual Welcome Packet to Members, at the conclusion of the state's open enrollment period, any letter or other pharmacy benefits related materials.
(4) Accepting and maintaining prescription drug claims and accumulator data from the PBM in a manner, format, and frequency specified by the State. The Contractor shall also share medical claims data and total claim amounts with the PBM for the purpose of allowing the TPA Contractor and the PBM to routinely track Member out of pocket maximums.
(5) Intervening with individual Network Providers, as identified by the Contractoror and as directed by the State, (1) whose prescribing practices appear to be operating outside industry or peer norms as defined by the State's Contractors, (2) are non-compliant as it relates to adherence to the State's formulary and/or generic prescribing patterns, and/or (3) who are failing to follow required PA processes and procedures. The goal of these interventions will be to improve prescribing practices by the identified Network Provider. Interventions shall be individualized, as requested by the State.

e. The state seeks to transition as much appropriate outpatient Specialty Drug dispensing as possible to our carved-out PBM or for those Specialty Drugs that are physician-administered to the most clinically appropriate cost effective site of care such as, physician's offices or home health from hospital inpatient and outpatient settings which tend to have higher costs. The state recognizes that some dispensing of Specialty Drugs will continue through the medical benefit, but seeks to reimburse providers for the provision of Specialty Drugs via our TPAs of these contracts on an ASP+ model. Refer to Contract Section C.3.g.

f. Each year, the Contractor shall provide the State with a financial reconciliation to show that they have met the aggregate ASP+ percentage standard for the previous calendar year. ASP+ is calculated for every drug filled with a pharmaceutical HCPCS code where an ASP was published at time of fill. Using ASP as of the date of fill; ASP% = Sum of Allowed Charges / Sum of (ASP times quantity). This report shall include but is not limited to; National Drug Code (NDC), HCPCS code, drug name, strength, number of units, place of service, paid amount, paid date, ASP, and ASP% and shall be provided each year no later than the last business day in May unless otherwise approved by the State. Refer also to Contract Attachment C, Reporting Requirements.

A.17. Behavioral Health

a. The Contractor is not responsible for providing benefits or paying claims for mental health and substance use (behavioral health) services, however, the Contractor shall play a role in ensuring Network Providers deliver Collaborative Physical/Behavioral Health Care to all patients with an identified chronic or persistent medical condition. Chronic or persistent medical conditions are defined as conditions with a duration of 4-12 weeks or longer.

b. The Contractor is responsible for working directly with the State's EAP/ BHO contractor. Coordination by the Contractor shall include the following:

(1) Inclusion of behavioral health benefit information in its Member handbook (see Contract Section A.14.c.), including the toll-free telephone number to contact the EAP/BHO contractor.
(2) Inclusion of the EAP/BHO contractor's telephone number on the back of the Member identification card (see Contract Section A.14.j.).
(3) Inclusion of behavioral health benefits information in the Contractor's annual enrollment materials and welcome packets for distribution to members as requested and approved by the State. Such materials shall include network lists, website information, toll-free member services number, policies and procedures, confidentiality statement and other updates and/or changes that may be helpful to the State's Members.
(4) Accepting and maintaining claims and accumulator data from the EAP/BHO in a manner, format, and frequency specified by the State. The Contractor shall also share medical claims data and claim amounts with the EAP/BHO for the purpose of allowing the TPA Contractor and the EAP/BHO to routinely track Member out of pocket maximums and for enhanced care management of Members.
(5) Assistance in the co-management of medical/mental disorders to include mixed protocol consultations when necessary between medical staff, Contractor staff, and EAP/BHO staff.
(6) Clinical education of Network Providers regarding screening and management of depression and anxiety in the primary care setting, including depression and anxiety as a secondary diagnosis.
(7) Providing individualized and face-to-face (when requested by the State) clinical education to Network Providers identified by the Contractor or the State as needing additional education regarding prescribing patterns and clinical interventions/treatment for behavioral health conditions.
(8) Participating, as applicable, in the EAP/BHO contractor's discharge activities for individual members with both medical and behavioral health needs.
(9) Other activities necessary for the appropriate coordination of benefits and claims payment of medical and behavioral health benefits.

c. The Contractor shall amend its provider agreements with primary care providers (at time of their renewal) to require network primary care providers to screen adults for depression when staff-assisted depression care supports are in place. Once such amendments are in place, the Contractor shall also include depression screening in an

adult wellness visit/physical as an element in any primary care chart reviews that it conducts. The goal is to ensure accurate diagnosis, effective treatment and follow-up. The lowest effective level of staff-assisted depression care support consists of a screening nurse who advises primary care providers of positive screening results and provides a protocol that facilitates referral to behavioral health treatment. The provider must document in the medical chart the screening and any necessary follow up that has been performed using a nationally-recognized, validated, reliable screening instrument.

A.18. Population Health Management and Wellness Services

a. The State contracts with a contractor to provide certain population health services, including wellness, weight management, and disease management. The Contractor is not responsible for the provision of these population health services. However, the Contractor is responsible for coordinating with the PH/W contractor as necessary to ensure that Members receive appropriate population health services. Coordination by the Contractor shall include the following:

(1) Inclusion of population health and wellness information in its member handbook (see Contract Section A.14.c.), including the toll-free telephone number to contact the PH/W contractor.
(2) Inclusion of the PH/W contractor's telephone number on the back of the member identification card (see Contract Section A.14.j.).
(3) Inclusion of population health benefits information in the Contractor's annual enrollment materials and welcome packets for distribution to Members as requested and approved by the State. Such materials shall include website information, toll-free member service number, policies and procedures, confidentiality statement and other updates and/or changes that may be helpful to the State's Members.
(4) Accepting and maintaining data from the PH/W contractor in a manner and format and at a frequency specified by the State.

b. As directed by the State, the Contractor shall implement cost-sharing incentives (*e.g.*, lower rates of Coinsurance, provision of Copayments in lieu of Coinsurance, waiver of or provision of lower Deductible amounts) for Members engaged in disease management and other programs as reported to the Contractor by the State or the PH/W contractor.

c. As directed by the State, the Contractor shall report to the PH/W contractor those Members who complete state specified wellness activities to earn incentives and/or requirements delivered by the Contractor such as, but not limited to, case management, preventive screenings, or other programs/activities. Refer also to Attachment C, Reporting Requirements.

A.19. Quality Assurance Program

a. The Contractor shall maintain a comprehensive quality assurance program that prospectively, concurrently and retrospectively ensures the quality of care provided by Network Providers as well as the quality of services provided by both Network Providers and the Contractor.

b. The Contractor shall submit to the State, at least one (1) month prior to Go-Live , a summary of its quality assurance program. The Contractor shall notify the State, In Writing, within thirty (30) days of any significant changes to its quality assurance program.

c. The Contractor shall establish a quality assurance committee comprised of qualified medical experts, including adequate representation of medical specialties, which shall

meet according to Contractor program policies and procedures. The quality assurance committee shall be responsible for evaluating the quality of care provided by Network Providers. Any person employed by the Contractor who identifies a potential quality of care issue involving a Network Provider shall submit it for investigation by the quality assurance committee. The committee shall promptly investigate any potential quality of care issues.

d. The Contractor shall review and assess the practice patterns of Network Providers to identify providers practicing outside of peer norms, specifically those identified with significant over-utilization and under-utilization of services or unusually low quality of care scores. The Contractor shall share its findings with Network Providers and take measures to maintain a quality, efficient and effective network of providers.

e. Unless otherwise directed by the State, the Contractor shall encourage its network hospitals and ambulatory surgery centers to complete the Leapfrog Surveys annually and shall provide a report of facility participation upon request.

f. Unless otherwise directed by the State, the Contractor shall complete the eValue8 process in 2022 and, thereafter, shall complete the process every other year during the term of this contract. This shall include, but not be limited to, completing the request for information survey, submitting the survey to the National Alliance of Healthcare Purchaser Coalitions and/or other entity as directed by the State, participating in the validation process, and participating in onsite visits with the State to discuss the results and identify areas for improvement. The Contractor shall also participate in specific eValue8 modules as requested by the State. Such modules may occur on a different timetable than the core process conducted every other year. The Contractor shall also participate in site visits to address the specific next steps and follow up on issues identified during the most recent eValue8 process.

g. The Contractor shall adopt and implement evidence-based clinical practice guidelines, protocols or pathways incorporating national criteria and local physician input as appropriate. Any provision of the Plan Documents and any guideline, protocol, or pathway in State law shall take precedence over any guideline, protocol, or pathway used by the Contractor. The Contractor's website (see Contract Section A.15.) shall contain all such guidelines, protocols, or pathways that are applicable to the Plans.

h. The Contractor shall maintain standards and protocols for tracking all incidents/potential issues with Network Providers (*e.g.*, Member complaints, irregular billing practices, and quality of care issues). In addition to responding to each incident/issue, the Contractor shall initiate a provider review when the number of incidents/issues reaches a threshold defined in advance by the Contractor. The Contractor shall specify the content of this review, which may range from medical chart audits to an outcomes analysis. The Contractor shall submit to the State at least one month prior to Go-Live, a summary of its standards, protocols, and thresholds for tracking incidents and issues with Network Providers and shall provide a report of the Network Provider tracking results upon request. The Contractor shall notify the State, In Writing, within thirty (30) days of any significant changes to its Network Provider tracking standards and protocols.

i. Whenever the Contractor identifies a potential quality of service or quality of care issue, the Contractor shall conduct appropriate follow-up, including taking corrective action as necessary to remedy a deficiency.

j. Unless otherwise directed by the State, qualified members of the Contractor's clinical staff shall participate in conference calls, at a frequency to be mutually determined, with the State's contractors (PBM, EAP/MHO, PH/W, etc.) to address issues or concerns regarding coordination of care for individual Members, particularly Members with complex needs. In preparation for each call, the Contractor shall identify Members and their issues/concerns, provide applicable documentation, including clinical information, to the

appropriate State contractors, and develop recommendations for resolving the issue/concern. The PBM, EAP/MHO contractor, PH/W contractor and/or the State may also identify Members.

k. As requested by the State, qualified members of the Contractor's staff shall participate in conference calls with the State and representatives from the other third party administrator for medical services, the PBM, the EAP/BHO contractor, the PH/W contractor, the H&W Center contractor, and/or other State contractors to improve coordination of their services to Members.

l. The Contractor shall obtain Health Plan Accreditation at a level of 4.0-5.0 stars by NCQA. If the Contractor is NCQA accredited as of Go-Live, the Contractor shall maintain such accreditation throughout the term of this Contract and submit annual certification of accreditation (refer also to Contract Attachment C, Reporting Requirements). If the Contractor is not NCQA accredited, or is not currently accredited at the required level, for its products as of Go-Live, the Contractor shall obtain such accreditation by December 31, 2022 (or a later date as specified by the State) and shall maintain it thereafter. Failure to obtain and maintain accreditation may result in liquidated damages as specified in Contract Attachment B.

m. The Contractor shall annually submit to the State a report, in a format approved by the State; with a three year trend of HEDIS results for Plan Members by Plan Group and combined, compared to its self-funded and fully-insured combined book of business products offered in the State, state benchmark, and national benchmark (refer also to Contract Attachment C, Reporting Requirements).

A.20. Fraud and Abuse

a. The Contractor shall implement procedures to prevent and detect fraud or abuse by providers or Members and shall perform fraud investigations of Members and providers, in consultation with the State, for the purpose of recovery of overpayments due to fraud.

b. The Contractor's procedures for preventing and detecting fraud and abuse shall include, at a minimum, claims edits, post-processing review of claims, utilization management, provider profiling and credentialing, and provisions in the Contractor's provider agreement and/or provider manual. The Contractor's claim edits shall include, at minimum, edits to identify upcoding and duplicate claims.

c. The State shall perform a quarterly review for potential duplicate claims payments to ensure the Contractor's claim edits are identifying duplicate claims and correcting any overpayments. Any duplicate claims identified as questionable by the State shall be submitted to the Contractor for further research. The Contractor shall respond within thirty (30) days of notification with additional claim detail to confirm or deny duplicate claims. Any confirmed duplicate claims shall be reprocessed to reimburse the State.

d. The Contractor shall perform a hospital/facility and professional claims review audit including elements not submitted on the claim such as medical record, itemized bill and manufacturer invoices for each claim with a total allowed amount equal to or greater than one hundred thousand dollars ($100,000) including but not limited to appropriate level of care coding and billing for miscellaneous items already included in the daily reimbursement grouper. The Contractor shall report the results of all hospital/facility and professional claims review audits at the semi-annual administration program review meetings.

e. In the event the Contractor discovers evidence that an unusual transaction has occurred that merits further investigation, the Contractor shall simultaneously inform BA and the

Division of State Audit, in the Office of the Comptroller of the Treasury. The State will review the information and inform the Contractor whether it wishes the Contractor to:

(1) Discontinue further investigation if there is insufficient justification; or
(2) Continue the investigation and report back to BA and the Division of State Audit; or
(3) Continue the investigation with the assistance of the Division of State Audit; or
(4) Discontinue the investigation and turn the Contractor's findings over to the Division of State Audit for its investigation.

f. The Contractor shall submit to the State, at least two (2) months prior to Go-Live, a copy of the documents describing its fraud and abuse program. The State reserves the right to review the documents and request changes, where appropriate. The Contractor shall notify the State, In Writing, within thirty (30) days of any significant changes to its programs related to insurance or provider fraud, abuse, and waste. The State reserves the right to review the change and request changes, where appropriate.

g. The Contractor shall report to the State at the semi-annual administration program review meetings, the effectiveness of the Contractor's fraud and abuse program, including its fraud and abuse detection activities, findings from those activities, follow-up on findings, proposed improvement activities, and any estimated savings to the Plans associated with the Contractor's detection of such fraudulent or wasteful activities.

A.21. Reporting & Systems Access

a. The Contractor shall submit all reports in a mutually agreeable electronic format (*e.g.*, Microsoft Word or Microsoft Excel), of the type, at the frequency, and containing the detail described in Contract Attachment C, Reporting Requirements. As appropriate, reporting shall continue during the claims runout period. Refer also to Contract Attachment D, SLA Scorecard.

b. The Contractor shall provide the State access to its internal client financial reporting system, including program and fiscal information regarding Members served, payable amounts, services rendered, claim level data etc. and the ability for said personnel to develop and retrieve reports. The Contractor shall provide training in and documentation on the use of this mechanism no later than two weeks prior to Go-Live. The Contractor shall provide access to this reporting functionality to a minimum of three (3) State employees no later than two weeks prior to the Go-Live date. Additional or replacement users may be added at any time at the State's request.

c. The Contractor shall provide requested State employees with access to the Contractor's enrollment system no later than two weeks prior to Go-Live, unless otherwise approved by the State In Writing. Additional or replacement users may be added at any time at the State's request. Access shall include the ability to do real-time updates to the Contractor's enrollment records.

d. The Contractor shall train the requested State staff (and any additional or replacement users) regarding access to the Contractor's system on all Contractor systems and tools no later than one (1) month prior to Go-Live. Such training may be delivered remotely or in-person.

e. The Contractor shall provide the State access to an ad-hoc reporting analyst to assist in the development of reports that cannot be generated using the Contractor's standard reporting package or cannot be generated in a usable format by the State. The Contractor shall deliver such reports to the State within five (5) Business Days of the State's request. If requested by the State, the Contractor shall deliver up to ten (10) reports annually deemed as "urgent" by the State, not including legislative bill analysis,

within two Business Days. All ad-hoc reports shall be provided at no additional cost to the State (see also Contract Attachment C, Reporting Requirements).

f. The Contractor is an insurance company and holder as defined by Tenn. Code Ann. § 66-29-102 for purposes of unclaimed property arising from the performance of this Contract. The Contractor shall comply with all applicable escheat state laws and regulations including but limited to Tenn. Code Ann. § 66-29-107. The Contractor shall be responsible for compiling reports which meet National Association of Unclaimed Property Administrators (NAUPA) specifications and filing any required reports with the State through the ReportItTN.gov online portal. The Contractor shall provide copies of all escheat reports and supporting documentation to the State upon request.

g. The Contractor shall ensure that reports submitted by the Contractor to the State shall meet the following standards:

(1) The Contractor shall verify the accuracy and completeness of data and other information in reports submitted.
(2) The Contractor shall ensure delivery of reports or other required data on or before scheduled due dates.
(3) Reports or other required data shall conform to the State's defined written standards.
(4) All required information shall be fully disclosed in a manner that is responsive and with no material omission.
(5) As applicable, the Contractor shall analyze the reports for any early patterns of change, identified trend, or outlier (catastrophic case) and shall submit a written summary with the report including such analysis and interpretation of findings. At a minimum, such analysis shall include the identification of change(s), the potential reasons for change(s), and the proposed action(s).
(6) The Contractor shall notify the State regarding any significant changes in its ability to collect information relative to required data or reports.
(7) The submission of late, inaccurate or otherwise incomplete reports shall be considered failure to report within the specified timeframe (see Contract Attachment D, Service Level Agreement).
(8) State requirements regarding reports, report content and frequency of submission may change during the term of the Contract. The Contractor shall have at least forty-five (45) days to comply with changes specified In Writing by the State.

A.22. Data Integration and Technical Requirements

a. The Contractor shall establish and maintain an electronic data interface with the State's Edison System for the purpose of processing State Member enrollment information at least three (3) months prior to Go-Live. The Contractor shall be responsible for providing and installing the hardware and software necessary. When the Contractor requires the exchange of PHI with the State of Tennessee, the State requires the use of second level authentication. This is accomplished using the State's standard software product, which supports PKI. The Contractor shall design a solution, in coordination with the State, to connect to the State's Secure File Transfer Protocol (SFTP) server using a combination of the password and the authentication certificate. The initial sign-on and transmission testing will use a password. Certificate testing may also be performed during the test cycle. Subsequent production sign-on will be done using the authentication certificate. The Contractor will then download the file and decrypt the file in its secure environment. The State of Tennessee uses public key encryption with Advanced Encryption Standard (AES) to encrypt PHI. If the State adopts a different or additional encryption standard or tool in the future, the Contractor shall, with adequate notice, cooperate with the State to maintain the security of protected information according to all applicable state and federal standards. Refer also to Attachment B, Liquidated Damages.

b. Notwithstanding the requirement to maintain enrollment data, the Contractor shall not perform changes to enrollment data without the State's approval. This prohibition shall include, but not necessarily be limited to: initiation, termination, and/or changes of coverage.

c. At least two (2) months prior to Go-Live, the Contractor shall complete testing of the transmission, receipt, and loading of the test enrollment file from the State.

d. At least one (1) month prior to Go-Live, the Contractor shall load, test, verify and make the State's enrollment information available online for use (refer also to Contract Attachment B, Liquidated Damages). The Contractor shall certify, In Writing, to the State that the Contractor understands and can fully accept and utilize the enrollment files as provided by the State, in the format provided by the State, with no modifications.

e. The Contractor shall maintain, in its systems, in-force enrollment records of all individuals covered by the Plans.

(1) Weekly Enrollment Update: To ensure that the State's enrollment records remain accurate and complete, the Contractor shall retrieve, unless otherwise directed by the State, via secure medium, weekly enrollment files from the State, in the State's Edison 834, which may be revised. Files will include full population records for all Members and will be in the format of ANSI ASC X12N, Benefit Enrollment and Maintenance 834 (5010), version 005010X220A1, with several fields customized by the State. Change files will not be sent.

(2) The Contractor and/or its subcontractors, shall electronically process one hundred percent (100%) of electronically transmitted enrollment updates, including the resolution of any errors identified during processing, within four (4) Business Days of receipt of the weekly file.

(3) The Contractor shall submit to the State a weekly enrollment file error report, in a format agreed upon by the State, within one (1) Business Day of receipt of the weekly file, which shall contain a) only errors that require correction and b) an indication of the correction required to resolve the error (also refer to Contract Attachment C, Report Requirements).

(4) The Contractor and/or its subcontractors shall resolve all additional enrollment discrepancies, not identified during processing, as identified by the State or Contractor within one (1) business day of identification (also refer to Attachment D, SLA Scorecard).

(5) The Contractor and/or its subcontractors, with collaboration from the State, shall resolve associated system errors, as identified through enrollment discrepancy resolution, in a timeframe mutually agreed upon with the State.

f. State Enrollment System Data Verification: Upon request by the State, not to exceed two (2) times annually, the Contractor shall submit to the State, in a secure manner, its full file of State Members, by which the State may conduct a data verification against the State's Edison database. The purpose of this data verification will be to determine the extent to which the Contractor is maintaining its database of State Members. The State will communicate results of this verification to the Contractor, including any Contractor requirements, and associated timeframes, for resolving the discrepancies identified.

g. CMS Data Match: The Contractor shall enter into an agreement with the Centers for Medicare and Medicaid Services (CMS) providing for a data match, no less frequent than quarterly, of Contractor's full file of Members against CMS Medicare files for purpose of determining the primary payer. Furthermore, the data match shall generate a report of all Medicare enrollees in a retirement benefit program including Head of Contract and dependents, and identify if they have both parts A and B and the effective dates, which shall be shared with the State. Refer also to Contract Attachment C, Reporting Requirements.

h. Local Government CMS Data Match: The Contractor shall also provide a monthly report of all Local Government retirees, incuding Head of Contract and dependents, who will become eligible for Medicare in the subsequent month (refer also to Contract Attachment C, Reporting Requirements).

i. CMS Data Match and Local Government CMS Data Match reports shall include, at a minimum, the following data elements:
   (1) Retiree budget code
   (2) Retiree benefit program
   (3) Retiree SSN
   (4) Edison ID number
   (5) Retiree First and Last Name
   (6) Retiree Date of birth
   (7) Retiree street address, City, State, ZIP
   (8) Effective date of coverage under state retirement health plan
   (9) Dependent SSN if they are Medicare eligible
   (10) Dependent First and Last Name if there are Medicare eligible
   (11) Dependent date of birth
   (12) Medicare part A effective date (date for the Member being reported; either retiree or dependent)
   (13) Medicare part A term date
   (14) Medicare part B effective date (date for the Member being reported; either retiree or dependent)
   (15) Medicare part B term date

j. The Contractor shall establish and maintain systems and processes to receive all appropriate and relevant data from entities and contractors providing services to Members, including contractors under contract with the State (*e.g.*, the PBM, EAP/BHO contractor, PH/W contractor, the H&W Center contractor, the HSA/FSA contractor) and integrate such data into Contractor's systems and processes as appropriate no later than one (1) month prior to Go-Live at no additional cost to the State.

k. The Contractor shall provide transmittal of claims data via secure medium at a frequency and format determined by the State to any additional third parties including the State's PH/W contractor, EAP/BHO contractor, PBM contractor, HSA/FSA contractor or others as identified by the State at no additional cost to the State.

l. Decision Support System

   (1) The Contractor shall transmit medical claims data to the State's current health care DSS contractor and, if directed by the State, to the Department of Finance and Administration, Office for Information Resources in the format detailed in RFP 31786-00148 Appendix 7.10 "DSS Vendor File format" or in a mutually agreed upon format. The data feed(s) shall be provided at no additional charge to the State. The Contractor shall transmit the claims data, via a mutually agreed upon secure methodology, no later than fifteen (15) days following the end of each calendar month, or more frequently as directed by the State, until all claims incurred during the term of this Contract have been paid. Refer also to Contract Attachment B, Liquidated Damages.
   (2) The Contractor shall ensure that all claims processed for payment have financial fields, valid NPIs, the complete most recent International Classification of Diseases codes and Current Procedural Terminology-4/HCPCS codes (and when applicable, updated versions of each). The file submitted to the State's current health care DSS contractor should contain data elements consistent with industry standards, such as those contained on the Uniform Bill-04, Center for Medicare and Medicaid Services 1450 and Center for Medicare and Medicaid Services 1500 forms and their successors. The Contractor shall add data as

required by the State's DSS contractor and/or the State for the purpose of processing claims data. The State has final approval for all file layouts.

(3) Claims data provided to the DSS contractor shall meet the quality standards detailed in Contract Attachment D, SLA Scorecard as determined by the State's DSS contractor. The Contractor shall not withhold any processed claims data from the file submission.

(4) The Contractor is responsible for the fee charged by the DSS contractor to develop, test and implement conversion programs for the Contractor's claims data. Furthermore, the Contractor shall pay during the term of this contract all applicable fees as assessed by the State's DSS contractor related to any data format changes or additions, which are Contractor-initiated or are due to meeting compliance with new regulations. The Contractor shall also pay all applicable fees related to any DSS contractor efforts to correct Contractor data quality errors that occur during the term of this contract.

(5) To the extent that the Contractor receives electronic lab results for laboratory tests performed by contract providers, the Contractor shall transmit these lab results to the State's DSS contractor in a mutually agreed upon format. The Contractor shall transmit the data, via a mutually agreed upon secure methodology, no later than fifteen (15) days following the end of each calendar month or more frequently as directed by the State.

(6) The Contractor shall recognize that the medical claims data transmitted pursuant to the provision of this Contract is owned by the State of Tennessee.

m. At the request of the State, the Contractor shall accept and load at least one (1) year of historical data from each current claims administrator no later than one (1) month prior to Go-Live and update/refresh the data until Go-Live. This includes, but is not limited to, claims history (with proprietary pricing and discount information redacted), provider data, Member data, and PA data.

n. The Contractor's systems shall conform to future federal and state specific standards for data exchange by the standard's effective date.

o. The Contractor shall partner with the State and Member agencies in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort.

p. Within sixty (60) days of notice of termination of this Contract, the Contractor shall transfer to the State all required data and records necessary to administer the plan(s)/program(s), subject to state and federal confidentiality requirements. The transfer shall be made electronically via secure medium, in a file format to be determined based on the mutual agreement between the State and the Contractor.

q. If a Member changes their benefit option or TPA outside of the Annual Enrollment Period, then the Contractor shall transfer to the new TPA or benefit option the in-network and out-of-network paid amounts, and any other accumulators, that would have otherwise been applied to the Member's current year plan account had the Member not made a change. The Contractor shall transfer said data to the Member's new TPA or benefit option within fourteen (14) calendar days and update the transferred data with new Paid Claims data. Likewise, the Contractor shall transfer any existing PA or utilization management information to the new TPA as appropriate. The Contractor shall also transfer said data to the State's other Contractors, with whom accumulator data is shared, within fourteen (14) calendar days. The Contractor shall also take all reasonable measures to facilitate the Member's transition, maintain the Member's continuity of care and service delivery, and minimize the administrative burden or other disruption to the Member.

A.23. Information Systems

a. The Contractor's systems shall have the capability of adapting to any future changes necessary as a result of modifications to the design of the Plans or this Contract and its requirements, including e.g., data collection, records and reporting based upon unique identifiers to track services and expenditures across population types/demographic groups, regions/parts of the state. The systems shall be scalable and flexible so they can be adapted as needed, within negotiated timeframes, e.g., in response to changes in Contract requirements or increases in enrollment estimates. The Contractor's system architecture shall facilitate rapid application of the more common changes that can occur in the Contractor's operation, including but not limited to:

(1) Changes in payment methodology;
(2) Provider reimbursement terms;
(3) Changes in service authorization and utilization management criteria;
(4) Changes in program management rules, e.g. eligibility for certain services; and
(5) Standardized contact/event/service codes.

b. The Contractor shall ensure that its electronic data processing (EDP) and electronic data interchange (EDI) environments (both hardware and software), data security, and internal controls meet all applicable federal and state standards, including HIPAA and the HITECH Act. Said standards shall include, but not be limited to, the requirements specified under HIPAA for each of the following:

(1) Electronic Transactions and Code Sets
(2) Privacy
(3) Security
(4) National Provider Identifier
(5) National Employer Identifier
(6) National Individual Identifier
(7) Claims attachments
(8) National Health Plan Identifier
(9) Enforcement

Unless the State prior approves In Writing the Contractor's use of alternate mitigating controls, the Contractor shall use Federal Information Processing Standards (FIPS) 140-2 compliant technologies to encrypt all PHI in motion or rest, including back-up media.

c. All Contractor systems shall maintain linkages and parent-child relationships between initial and related subsequent interactions/transactions/events/activities. Additionally, when the Contractor houses indexed images of documents used by Members, providers and subcontractors to transact with the Contractor, the Contractor shall ensure that these documents maintain logical relationships to certain key data such as Member identification and provider/subcontractor identification numbers. The Contractor shall also ensure that records associated with a common event, transaction or customer service issue have a common index that will facilitate search, retrieval and analysis of related activities, e.g., interactions with a particular Member about the same matter/problem/issue.

d. Upon the State's request, the Contractor shall be able to generate a listing of all Members and providers that were sent a particular document, the date and time that the document was generated, and the date and time that it was sent to particular Members or providers or groups thereof. The Contractor shall also be able to generate a sample of said document.

e. Retention and Accessibility of Information

(1) The Contractor shall provide, one (1) month prior to Go-Live, and maintain a comprehensive information retention plan that is in compliance with state and federal requirements.

(2) The Contractor shall maintain information on-line for a minimum of three (3) years, based on the last date of update activity, and update detailed and summary history data monthly for up to three (3) years to reflect adjustments.

(3) The Contractor shall provide forty-eight (48) hour turnaround or better on requests for access to information that is between three (3) years and six (6) years old, and seventy-two (72) hour turnaround or better on requests for access to information in machine readable form that is between six (6) and ten (10) years old.

(4) If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

f. Information Ownership. All information, whether data or documents, and reports that contain or make references to said information, involving or arising out of this Contract is owned by the State. All contract related information retained by the Contractor including but not limited to, communications and files related to plan members, shall be made available to the State upon request. The Contractor is expressly prohibited from sharing or publishing State information and reports or releasing such information to external entities, Affiliates, parent company, or subsidiaries beyond the extent necessary to perform the duties outlined within this contract without the prior written consent of the State, which consent will not unreasonably be withheld.

g. System Availability

(1) The Contractor shall ensure that critical Member, provider and other web-accessible and/or telephone-based functionality and information, including the website described in Section A.15., are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled system unavailability agreed upon by the State and the Contractor. Unavailability caused by events outside of the Contractor's Span of Control is outside of the scope of this requirement. Any scheduled maintenance shall occur between the hours of midnight and 5:00 a.m. Central Time and shall be scheduled in advance with notification on the member website. The Contractor shall make efforts to minimize any down-time between 5:00 a.m. and 10:00 p.m. Central Time.

(2) The Contractor shall ensure that the systems within its Span of Control that support its data exchanges with the State and the State's contractors are available and operational according to the specifications and schedule associated with each exchange.

h. Prior to implementing any major modification to or replacement of the Contractor's core Information Systems functionality and/or associated operating environment, the Contractor shall notify the State In Writing of the change or modification within a reasonable amount of time (commensurate with the nature and effect of the change or modification) if the change or modification: (a) would affect the Contractor's ability to perform one or more of its obligations under this Contract; (b) would be visible to State system users, Members and providers; (c) might have the effect of putting the Contractor in noncompliance with the provisions or substantive intent of the Plan Documents and/or this Contract; or (d) would materially reduce the benefits payable or services provided to the average Member. If so directed by the State, the Contractor shall discuss the proposed change with the State/its designee prior to implementing the change. Subsequent to this discussion, the State may require the Contractor to demonstrate the readiness of the impacted systems prior to the effective date of the actual modification or replacement.

i. System and Information Security and Access Management Requirements

(1) The Contractor's systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

i. Restrict access to information on a "least privilege" basis, e.g., users permitted inquiry privileges only will not be permitted to modify information;
ii. Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities and the ability to create, change or delete certain data (global access to all functions shall be restricted to specified staff jointly agreed to by the State and the Contractor);
iii. Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences; and.
iv. Ensure that authentication credentials are not passed in clear text or otherwise displayed or presented.

(2) The Contractor shall make system information available to duly authorized representatives of the State and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.
(3) The Contractor's systems shall contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be mutually agreed upon by the Contractor and the State.
(4) Audit trails shall be incorporated into all systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

i. Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;
ii. Have the date and identification "stamp" displayed on any on-line inquiry;
iii. Have the ability to trace data from the final place of recording back to its source data file and/or document;
iv. Be supported by listings, transaction reports, update reports, transaction logs, or error logs; and
v. Facilitate batch audits as well as auditing of individual records.

(5) The Contractor's systems shall have inherent functionality that prevents the alteration of finalized records.
(6) The Contractor shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The Contractor shall provide the State with access to data facilities upon request. The physical security provisions shall be in effect for the life of this Contract.
(7) The Contractor shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.
(8) The Contractor shall include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

(9) The Contractor shall put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of the Contractor's Span of Control.

(10) The Contractor shall conduct a security risk assessment at least annually and communicate the results to the State in compliance with Contract Attachment E. The first report shall be provided one (1) month prior to Go-Live and annually thereafter (refer also to Contract Attachment C, Reporting Requirements). The risk assessment shall also be made available to appropriate state and federal agencies. At a minimum the assessment shall contain the following: identification of loss risk events/ vulnerabilities; analysis of the probability of loss risk and frequency of events; estimation of the impact of said events; identification and discussion of options for mitigating identified risks; cost-benefit analysis of options; recommended options and action plan for their implementation. The assessment shall be conducted in accordance with the following: requirements for administrative, physical, and technical safeguards to protect health data (45 CFR §§164.304 - 318); rules for conducting risk analysis and risk management activities (45 CFR §164.308); requirements for security awareness training (45 CFR §164.308(a)(5)); requirements for entities to have security incident identification, response, mitigation and documentation procedures (45 CFR §164.308(a)(6)).

(11) To maintain the privacy of PHI, the Contractor shall enable Transport Layer Security (TLS) on the mail server used for daily communications (i.e. email) between the State and the Contractor. TLS shall be enabled no later than Go-Live and shall remain in effect throughout the term of the contract.

A.24. Audit Authority

a. Upon thirty (30) days written notice and the establishment of applicable third party confidentiality agreement(s), if any, reasonably required by the Contractor, the State and/or its representative shall have the right to examine and audit the Contractor services and pricing to ensure compliance with all applicable requirements. For the purpose of this requirement, the term, "Contractor," shall include its parent organization, Affiliates, subsidiaries, and subcontractors.

b. The State has sole authority to determine who to choose for any kind of audit related to the services contained in the contract. This includes, but does not limit the selection to, state employees, state employees from the Comptroller's audit staff, and BA's consulting firm.

c. If the State contracts with a private entity (non-state employees) to conduct an audit of the Contractor, the State will require the auditing entity to negotiate a reasonable confidentiality agreement with the Contractor. The Contractor shall not attempt to limit the State's audit rights in any way or timeframe; the State in its sole authority and with execution of any confidentiality document shall be allowed to audit the Contractor on any contracted service, claims processing, customer service, or any other provision of this contract by whomever the State in its sole authority deems appropriate.

d. In no instance shall the Contractor advise the State that one set of auditors is appropriate while another set is not. In addition, the State may audit or re-audit any time period in accordance with the timeframe for audits listed in Contract Section D.11. Previous audits of a set of claims, providers, time periods, or any other sort of audit does not negate the State's right to re-audit the same information again later. There shall be no audit blackout periods at any point during a year and any charges or fees in any form for any audits that the State chooses to exercise.

e. The Contractor shall provide access, at any time during the term of this contract and for five (5) years after final contract payment (longer if required by law), to the State and/or

its representative to examine and audit Contractor services, payments, and pricing pursuant to this Contract. The State reserves the right to request that documentation be provided for review at the representative's location, the State's location, or at the Contractor's corporate site.

f. The Contractor shall, at its own cost, provide the State and/or its representative with prompt and complete access to any data, data extracts, documents, access to systems, and other information necessary to ensure Contractor compliance with all requirements of this Contract.

g. The Contractor shall provide reasonable cooperation with requests for information, which includes but is not limited to the timing of the audit, deliverables, data/information requests and the Contractor's response time to the State's questions during and after the process. The Contractor shall provide written responses to all 'findings' received during the audit process to assist in clarification and suggested resolutions. The Contractor shall also provide a formal audit response within thirty (30) days of the audit conclusion, or at a later date if mutually determined with the State to be more reasonable based on the number and type of findings.

h. The Contractor shall fund the following audits which shall be conducted by a qualified organization or representative chosen by the State and the scope of the audit shall be defined by the State:
   (1) A pre-implementation audit to review, at a minimum, whether the Contractor's adjudication system is configured according to the State's benefit design;
   (2) An operational audit focusing on, at a minimum, staffing, customer service capabilities, TPA audit programs, and claims administration; and
   (3) Any follow-up audits if significant deficiencies, as determined by the State, are noted.

i. The State shall not be responsible for time or any costs incurred by the Contractor in association with an audit including, but not limited to, the costs associated with providing data, reports, documentation, systems access, or space.

j. If the outcome of the audit results in an amount due to the State, the Contractor shall pay the amount due within (30) thirty days of final audit report notification from the State. Any amount due the State which is not paid within (30) thirty days of the final audit report will be deducted from the total amount due from the fees due to the Contractor pursuant to C.3 until the full amount due is paid. If the Contractor disagrees with a finding resulting in a payment to the State, the State will review the Contractor's comments, but if the State retains the original audit findings the Contractor will be responsible for any payment to the State

A.25. Warranty

Contractor represents and warrants that the term of the warranty ("Warranty Period") shall be the greater of the Term of this Contract or any other warranty generally offered by Contractor, its suppliers, or manufacturers to customers of its goods or services. The goods or services provided under this Contract shall conform to the terms and conditions of this Contract throughout the Warranty Period. Any nonconformance of the goods or services to the terms and conditions of this Contract shall constitute a "Defect" and shall be considered "Defective." If Contractor receives notice of a Defect during the Warranty Period, then Contractor shall correct the Defect, at no additional charge.

Contractor represents and warrants that the State is authorized to possess and use all equipment, materials, software, and deliverables provided under this Contract.

Contractor represents and warrants that all goods or services provided under this Contract shall be provided in a timely and professional manner, by qualified and skilled individuals, and in conformity with standards generally accepted in Contractor's industry.

If Contractor fails to provide the goods or services as warranted, then Contractor will re-provide the goods or services at no additional charge. If Contractor is unable or unwilling to re-provide the goods or services as warranted, then the State shall be entitled to recover the fees paid to Contractor for the Defective goods or services. Any exercise of the State's rights under this Section shall not prejudice the State's rights to seek any other remedies available under this Contract or applicable law.

A.26. Inspection and Acceptance

The State shall have the right to inspect all goods or services provided by Contractor under this Contract. If, upon inspection, the State determines that the goods or services are Defective, the State shall notify Contractor, and Contractor shall re-deliver the goods or provide the services at no additional cost to the State. If after a period of thirty (30) days following delivery of goods or performance of services the State does not provide a notice of any Defects, the goods or services shall be deemed to have been accepted by the State.

B. TERM OF CONTRACT:

This Contract shall be effective on June 1, 2021 ("Effective Date") and extend for a period of ninety-seven (97) months after the Effective Date ("Term"). This provides for seven (7) months of implementation, seventy-two (72) months of service delivery to members, and eighteen (18) months for claims runout. The State shall have no obligation for goods or services provided by the Contractor prior to the Effective Date.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Written Dollar Amount ($Number) ("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.

a. The Contractor's compensation shall be contingent upon the satisfactory provision of goods or services as set forth in Section A.

b. The Contractor shall be compensated based upon the following payment methodology:

(1) Total Enrollment Level-Based Fee.

INSERT PAYMENT TABLES for enrollment in the Efficient Network and Broad Network, if offered by the State:

The Contractor shall be compensated based upon the following payment rates for optional Expert Medical Opinion services implemented at the direction of the State:

(1) Case Rate Fee.

INSERT PAYMENT TABLE

c. The Contractor shall maintain an annual medical trend rate proposed by the Contractor for plan years 2023-2027 at or below four percent (4%), with 2022 setting the base year. During any plan year, if the trend rises above the guarantee, as calculated by the State's consulting actuary, using allowed amounts for in-network claims incurred, the Contractor guarantees to reimburse the State or have withheld the administrative fees detailed in the table below within thirty (30) days of notification.

INSERT TREND GUARANTEE TABLE

d. Claims Payments. The State will fund the Contractor for the total issue amount of the claims payments, net of cancellations, voids or other payment credit adjustments. Unless otherwise mutually agreed In Writing by the parties, the Contractor shall notify the State of the funding amount required and the State will fund the Contractor at least weekly, provided that the Contractor's payment process includes timely settlement of ACH transactions. As the parties shall mutually agree In Writing, the transfer of said funding to the Contractor for claims payments shall be effected at least weekly by ACH debit from the Contractor to a designated State bank account.

(1) The Contractor acknowledges and agrees that since the State intends to fund payments at the time of issuance, the State will not maintain a separate bank account or an escrow account with the Contractor or to otherwise pre-fund an account.
(2) The State reserves the right to review documentation either before or after the transfer of funding for claims payments and, as the State may deem appropriate, to adjust the funding amount to be transferred or withhold the amount of any overpaid funding from another funding transfer.
(3) The Contractor acknowledges that funding for Claims Payments shall be adjusted in full consideration of the Contract Scope of Service requirement that the Contractor shall identify and pursue claims that may be subject to coordination of benefits (COB); see Contract Section A.12.

e. The State shall reimburse the Contractor for the actual cost of the following in the performance of this Contract, provided that the Contractor provides documentation of actual costs incurred as required by the State.

(1) Postage. In a situation where unanticipated plan modifications would require notification to plan Members that is not detailed in the terms and conditions of this Contract, the State may request that the Contractor produce and mail such notification to Plan Members. In such extreme situations, the State shall reimburse the Contractor only for the actual cost of postage for mailing materials produced at the specific direction of the State and authorized by the State.
(2) Printing / Production. The State shall reimburse the Contractor an amount equal to the actual net cost of document printing / production as required and authorized by the State as described in Contract Section C.3.d above.

Additionally, if error(s) in Member materials, approved by the State In Writing, are detected after the materials have been mailed, the State will reimburse the Contractor for the production and postage cost of mailing the corrected version.

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

f. The State authorizes the Contractor to retain monies received through subrogation, on a per patient basis, of no more than 5% of the gross recoveries received. The Contractor may retain an additional 20% of the gross recoveries, when such recoveries are made by subrogation subcontractor(s). The Contractor's subrogation processes shall include the recovery of claims paid as a result of work related illnesses or injuries relative to worker's compensation claims.

g. During the term of this contract the average, aggregate reimbursement for all Specialty Drugs dispensed in a physician's office, hospital setting (outpatient), or any other setting (including but not limited to oncology clinics) shall not exceed:

Plan Year2022	Plan Year 2023	Plan Year 2024	Plan Year 2025	Plan Year 2026	Plan Year 2027
ASP + 31%	ASP + 31%	ASP + 31%	ASP + 30%	ASP + 30%	ASP + 30%

Compliance with the aggregate ASP+ percentage standard for the previous calendar year will be reconciled annually using the ASP drug pricing files from CMS and reported to the State in the ASP reconciliation report (see Contract Sections A.16.f and Contract Attachment C, Reporting Requirements). The reconciliation shall be validated by the State's consulting actuary and all monies exceeding the above guaranteed limits will be payable to the State by the Contractor within thirty (30) days of state notification.

h. Value Based Payments. The State shall reimburse the Contractor for approved costs resulting from any State approved value based initiatives.

i. Amounts due the State. The Contractor will remit amounts due the State that cannot be properly offset against recent claims no less than quarterly (e.g. funds received during run out period for subrogation cases or fraud repayments). Amounts owed the State of more than $25,000 are payable within 30 days.

C.4. At-Risk Performance Payments and SLA Scorecard. The Parties shall conduct a scorecard assessment (Contract Attachment D), beginning after Go-Live, on a quarterly basis (every three months) during the Term. Based on the SLA Scorecard, Contractor shall send the State an At-Risk Performance Payment (if applicable) quarterly (every three months) during the Term in accordance with Contract Attachment D. This payment is due within forty-five (45) calendar days of the quarterly SLA scorecard assessment.

C.5. Travel Compensation. The Contractor shall not be compensated or reimbursed for travel time, travel expenses, meals, or lodging.

C.6. Purchase Order in lieu of Invoice. The State will generate a monthly purchase order and initiate payment of the purchase order for the administration fees, based upon the State's record of enrolled Members as of the first day of the month, utilizing the rates listed in C.3. above.

C.7. Reconciliation of Payment. The Contractor shall reconcile, within ten (10) Business Days of receipt, payment information provided by the State. Upon identification of any discrepancies, the Contractor shall immediately advise the State.

C.8. Payment of Purchase Order. A payment by the State shall not prejudice the State's right to object to or question any payment, purchase order, 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 reflected on the purchase order.

C.9. Payment Reductions. The Contractor's payment shall be subject to reduction for amounts included in any purchase order 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.10 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 for case rates 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:

Seannalyn Brandmeir, Procurement and Contracting Director
Tennessee Department of Finance & Administration
Division of Benefits Administration
312 Rosa L. Parks Avenue, Suite 1900
Nashville, Tennessee 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) Contract number (assigned by the State);
(4) Customer account name: Department of Finance & Administration, Division of Benefits Administration;
(5) Customer account number (assigned by the Contractor to the above-referenced Customer);
(6) Contractor name;
(7) Contractor Tennessee Edison registration ID number;
(8) Contractor contact for invoice questions (name, phone, or email);
(9) Contractor remittance address;
(10) Description of delivered goods or services provided and invoiced, including identifying information as applicable;
(11) Number of delivered or completed units, increments, hours, or days as applicable, of each good or service invoiced;
(12) Applicable payment methodology (as stipulated in Section C.3.) of each good or service invoiced;
(13) Amount due for each compensable unit of good or service; and
(14) 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.10

C.11. 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.12. 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.13. 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.14. 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 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:

Seannalyn Brandmeir, Procurement and Contracting Director
Tennessee Department of Finance & Administration
Division of Benefits Administration
312 Rosa L. Parks Avenue, Suite 1900
Nashville, Tennessee 37243
Seannalyn.Brandmeir@tn.gov

Telephone: 615.532.4598
Fax: 615.253.8556

The Contractor:

Contractor Contact Name & Title
Contractor Name
Address
Email Address
Telephone # Number
FAX # Number

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, or if the Contractor materially violates any terms of this Contract ("Breach Condition"), the State shall provide written notice to Contractor specifying the Breach Condition. If within thirty (30) days of notice, the Contractor has not cured the Breach Condition, the State may 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 of this Contract by the Contractor 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.

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 from 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, 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. The Contractor's liability for all claims arising under this Contract shall be limited to an amount equal to one times the total Paid Claims, as defined in Contract Section A.2., that have processed throughout the one year of contract performance immediately preceding the breach. If the breach occurs in the first year of the contract, the calculation will be based on processed claims from the beginning of contract performance until the date of the breach, prorated to equal one year, 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' fees, court costs, expert witness fees, and other litigation expenses 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.

e. The Contractor shall not sell Public Sector Plan Member information or use Member information unless it is aggregated blinded data, which is not identifiable on a Member basis. The State must approve, In Writing, the use of and sale of any of our Member or Plan data, even if being used in an aggregated, blinded data format.

f. The Contractor shall not use Plan Member identified or non-aggregated information for advertising, marketing, promotion or any activity intended to influence sales or market share of any product or service except when permitted by the State, such as advertisements of the Program for enrollment purposes.

g. The Contractor shall have full financial responsibility for any penalties, fines, or other payments imposed or required as a result of the Contractor's non-compliance with or violation of HIPAA or HITECH requirements, and the Contractor shall indemnify the State with respect to any such penalties, fines, or payments, including the cost of credit

protection. At the request of the State, the Contractor shall offer credit protection for those times in which a Member's PHI is accidentally or inappropriately disclosed.

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, disqualified, or presently fall under any of the prohibitions of sections a-d.

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.

D.26. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee, without regard to its conflict or choice of law rules. 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 - 408.

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:
    (1) Contract Attachment A Attestation;
    (2) Contract Attachment B Liquidated Damages;
    (3) Contract Attachment C Reporting Requirements;
    (4) Contract Attachment D Service Level Agreement Scorecard; and
    (5) Contract Attachment E HIPAA Business Associate 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;
f. the Contractor's response seeking this Contract; and
g. any Contractor rules or policies contained in insurance policy filings by the Contractor with State regulators.

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 fifteen (15) 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 claim. 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. Professional Liability Insurance

1) Professional liability insurance shall be written on an occurrence basis or on a claims-made basis. If this coverage is written on a claims-made basis, then:

i. The retroactive date must be shown, and must be on or before the earlier of the Effective Date of the Contract or the beginning of Contract work or provision of goods and services;

ii. Insurance must be maintained and evidence of insurance must be provided for at least five (5) full years from the date of the final Contract payment; and

iii. If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a retroactive date on or prior to the Contract Effective Date, the Contractor must purchase "extended reporting" or "tail coverage" for a minimum of five (5) full years from the date of the final Contract payment.

2) Any professional liability insurance policy shall have a limit not less than one million dollars ($1,000,000) per claim and two million dollars ($2,000,000) in the aggregate; and

3) If the Contract involves the provision of services by medical professionals, a policy limit not less than three million ($3,000,000) per claim and three million dollars ($3,000,000) in the aggregate for medical malpractice insurance.

d. Technology Professional Liability (Errors & Omissions)/Cyber Liability Insurance

1) The Contractor shall maintain technology professional liability (errors & omissions)/cyber liability insurance appropriate to the Contractor's profession in an amount not less than ten million dollars ($10,000,000) per occurrence or claim and ten million dollars ($10,000,000) annual aggregate, covering all acts, claims, errors, omissions, negligence, infringement of intellectual property (including copyright, patent and trade secret); network security and privacy risks, including but not limited to unauthorized access, failure of security, information theft, damage to destruction of or alteration of electronic information, breach of privacy perils, wrongful disclosure and release of private information, collection, or other negligence in the handling of confidential information, and including coverage for related regulatory fines, defenses, and penalties.

2) Such coverage shall include data breach response expenses, in an amount not less than ten million dollars ($10,000,000) and payable whether incurred by the State or Contractor, including but not limited to consumer notification, whether or not required by law, computer forensic investigations, public relations and crisis management firm fees, credit file or identity monitoring or remediation services and expenses in the performance of services for the State or on behalf of the State hereunder.

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.

D.34. 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. 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. 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. 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.

E.3. Software Support and Maintenance Warranty. Contractor shall provide to the State all software upgrades, modifications, bug fixes, or other improvements in its software that it makes generally available to its customers.

E.4. 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.5. 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 Solicitation Number RFP 31786-00148 (RFP Attachment 6.2, Section B.13) 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, service-

disabled veterans, and persons with disabilities. Such reports shall be provided to the State of Tennessee Governor's Office of Diversity Business Enterprise in the TN Diversity Software available online at:
https://tn.diversitysoftware.com/FrontEnd/StartCertification.asp?TN=tn&XID=9810.

E.6. Liquidated Damages. If the Contractor fails to perform in accordance with any term or provision of this contract, only provides partial performance of any term or provision of the Contract, violates any warranty, or any act prohibited or restricted by the Contract occurs, ("Liquidated Damages Event"), the State may assess damages on Contractor ("Liquidated Damages"). The State shall notify the Contractor of amounts to be assessed as Liquidated Damages. The Parties agree that due to the complicated nature of the Contractor's obligations under this Contract it would be difficult to specifically designate a monetary amount for Contractor's failure to fulfill its obligations regarding the Liquidated Damages Event as these amounts are likely to be uncertain and not easily proven. Contractor has carefully reviewed the Liquidated Damages contained in Attachment B and agrees that these amounts represent a reasonable relationship between the amount and what might reasonably be expected in the event of a Liquidated Damages Event, and are a reasonable estimate of the damages that would occur from a Liquidated Damages Event. The Parties agree that the Liquidated Damages represent solely the damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party. The Contractor agrees that the Liquidated 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 before availing itself of any other remedy. The State may choose to discontinue Liquidated Damages and avail itself of any other remedy available under this Contract or at law or equity.

E.7. 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 or ensure that Contractor is in full compliance with its obligations under this Contract in relation to PII. In accordance with the timeframe for audits listed in Contract Section D.11 and in consultation with the State, 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. The obligations set forth in this Section shall survive the termination of this Contract.

E.8. Contractor Hosted Services Confidential Data, Audit, and Other Requirements

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 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. "Application" shall mean the computer code that supports and accomplishes the State's requirements as set forth in this Contract. "Penetration Tests" shall be in the form of attacks on the Contractor's computer system, with the purpose of discovering security weaknesses which have the potential to gain access to the Processing Environment's features and data. The "Vulnerability Assessment" shall be designed and executed to define, identify, and classify the security holes (vulnerabilities) in the Processing Environment. The Contractor shall commission an independent third party to perform the risk assessment which must include penetration testing and vulnerability assessments. The Contractor shall provide the results of the third party testing to the State.

(4) 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. The Contractor shall maintain a duplicate set of all records relating to this Contract in electronic medium, usable by the State and the Contractor for the purpose of Disaster recovery. Such duplicate records are to be stored at a secure fire, flood, and theft- protected facility located away from the storage location of the originals. The Contractor shall update duplicate records, at a minimum, on a daily basis and shall retain said records for a period of sixty (60) days from the date of creation.

(5) In accordance with the timeframe for audits listed in Contract Section D.11 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.

(6) Contractor must enter into a Business Associate Agreement (BAA) with the State. See Contract Attachment E.

b. Minimum Requirements

(1) The Contractor and all data centers used by the Contractor to host State data, including those of all Subcontractors, must comply with the State's Enterprise Information Security Policies as amended periodically. The State's Enterprise Information Security Policies document is found at the following URL: https://www.tn.gov/finance/strategic-technology-solutions/strategic-technology-solutions/sts-security-policies.html.

(2) The Contractor agrees to maintain the Application so that it will run on a current, manufacturer-supported Operating System. "Operating System" shall mean the software that supports a computer's basic functions, such as scheduling tasks, executing applications, and controlling peripherals.

(3) 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.

c. Comptroller Audit Requirements

Upon reasonable notice and at any reasonable time, the Contractor and Subcontractor(s) agree to allow the State, the Comptroller of the Treasury, or their duly appointed representatives to perform information technology control audits of the Contractor and all Subcontractors used by the Contractor. Contractor will maintain and cause its Subcontractors to maintain a complete audit trail of all transactions and activities in connection with this Contract. Contractor will provide to the State, the Comptroller of the Treasury, or their duly appointed representatives access to Contractor and Subcontractor(s) personnel for the purpose of performing the information technology control audit.

The information technology control audit may include a review of general controls and application controls. General controls are the policies and procedures that apply to all or a large segment of the Contractor's or Subcontractor's information systems and applications and include controls over security management, access controls, configuration management, segregation of duties, and contingency planning. Application controls are directly related to the application and help ensure that transactions are complete, accurate, valid, confidential, and available. The audit shall include the Contractor's and Subcontractor's compliance with the State's Enterprise Information Security Policies and all applicable requirements, laws, regulations or policies.

The audit may include interviews with technical and management personnel, physical inspection of controls, and review of paper or electronic documentation.

For any audit issues identified, the Contractor and Subcontractor(s) shall provide a corrective action plan to the State within 30 days from the Contractor or Subcontractor receiving the audit report.

Each party shall bear its own expenses incurred while conducting the information technology controls audit.

d. 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) The BC-DR plan shall encompass all Information Systems supporting this Contract. At a minimum the Contractor's BC-DR plan shall address and provide the results for the following scenarios:

i. Central and/or satellite data processing, telecommunications, print and mailing facilities and functions therein, hardware and software are destroyed or damaged;
ii. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage;
iii. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that compromise the integrity of data maintained in a live or archival system; and
iv. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the system.

(2) "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: one (1) hour.

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: seventy-two (72) hours.

(3) 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 Recovery Test that its Disaster Recovery Capabilities meet the RPO and RTO requirements. The Contractor shall submit a written summary of its annual BC-DR test results to the State (see also Contract Attachment C, Reporting Requirements).

e. The Contractor and any Subcontractor used by the Contractor to host State data, including data center vendors, shall be subject to an annual engagement by a CPA firm in accordance with the standards of the American Institute of Certified Public Accountants ("AICPA") for a System and Organization Controls for service organizations ("SOC") 2 Type II audit. The SOC audit control objectives shall include all five trust services principles. The Contractor shall provide the State with the Contractor's and Subcontractor's annual audit report within 30 days from when the CPA firm provides the audit report to the Contractor or Subcontractor and in addition to periodic bridge reports as requested by the State, see also Contract Attachment C, Reporting Requirements. The Contractor shall submit corrective action plans to the State for any issues included in

the audit report within 30 days after the CPA firm provides the audit report to the Contractor and Subcontractor.

If the scope of the most recent SOC audit report does not include all of the current State fiscal year, upon request from the State, the Contractor must provide to the State a letter from the Contractor or Subcontractor stating whether the Contractor or Subcontractor made any material changes to their control environment since the prior audit and, if so, whether the changes, in the opinion of the Contractor or Subcontractor, would negatively affect the auditor's opinion in the most recent audit report.

No additional funding shall be allocated for these audits as they are included in the Maximum Liability of this Contract.

E.9. Extraneous Terms and Conditions. Contractor shall fill all orders submitted by the State under this Contract. No purchase order, invoice, or other documents associated with any sales, orders, or supply of any good or service under this Contract shall contain any terms or conditions other than as set forth in the Contract. Any such extraneous terms and conditions shall be void, invalid and unenforceable against the State. Any refusal by Contractor to supply any goods or services under this Contract conditioned upon the State submitting to any extraneous terms and conditions shall be a material breach of the Contract and constitute an act of bad faith by Contractor.

E.10. Survival. The terms, provisions, representations, and warranties contained in this Contract which by their sense and context are intended to survive the performance and termination of this Contract, shall so survive the completion of performance and termination of this Contract.

IN WITNESS WHEREOF,

CONTRACTOR LEGAL ENTITY NAME:

CONTRACTOR SIGNATURE **DATE**

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

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

Howard H. Eley, Chairman **DATE**

ATTACHMENT A

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

CONTRACT ATTACHMENT B

PERFORMANCE GUARANTEES AND LIQUIDATED DAMAGES

To effectively manage contractual performance, the State has established Liquidated Damages associated with the Contractor's obligations with respect to the Contract. The Contractor is expected to perform according to a certain level of standards. If these standards are not met, the State is entitled to impose liquidated damage assessments. Damages are included in this Attachment.

The Parties agree that the Liquidated Damages represent solely the anticipated damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party.

Payment of Liquidated Damages: It is agreed by the State and the Contractor that any liquidated damages assessed by the State shall be due and payable to the State within forty-five (45) calendar days after Contractor receipt of the Invoice containing an assessment of Liquidated Damages. If payment is not made by the due date, the Liquidated Damages amount may be withheld from future payments by the State without further notice.

1. Implementation	
Guarantee	The Contractor shall complete all tasks, deliverables, and milestones included in the project implementation plan, as required in Contract Section A.3.e. necessary to install the program by Go-Live.
Assessment	One thousand dollars ($1,000) for each Business Day for each late deliverable and/or milestone leading up to and by Go-Live.
Justification	The Implementation Plan is a critical portion of the implementation of a new contract and needed before starting implementation to ensure all aspects of implementation are enacted accurately and timely. This assessment calculates the potential impact of missed or inaccurate implementation milestones.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live.
2. Operational Readiness	
Guarantee	The Contractor shall resolve all findings identified by the State during its operational readiness review, as required in Contract Section A.3.f., prior to Go-Live.
Assessment	Ten thousand dollars ($10,000) per finding if the issue is not resolved prior to Go-Live.
Justification	Operational readiness review requires the Contractor and the State to investigate and navigate any potential issues, deadlines, and milestones leading up to Go-Live and operations.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live.
3. Edison System Interface	
Guarantee	Contractor's interface with the Edison System shall be fully operational by the date specified in Contract Section A.22.a
Assessment	Ten thousand dollars ($10,000) per Business Day beyond the deadline that the interface is not fully operational.
Justification	This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live.
4. Call Center Operational	
Guarantee	The Contractor's call center shall be fully operational no later than the date specified in Contract Section A.11.b.
Assessment	Ten thousand dollars ($10,000) for every Business Day beyond the deadline that the call center or other system is not operational.
Justification	This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live.
5. Program Go-Live Date	

Guarantee	All medical claims administrative services for the Public Sector Plans shall take effect (*i.e.*, "go-live") and be fully operational on or before Go-Live.
Assessment	Twenty-five thousand dollars ($25,000) for each Business Day beyond Go-Live that medical claims administrative services are not fully operational.
Justification	Program go-live is an imperative performance guarantee listed in the Contract. If there is a delay in this, the State is unable to provide medical benefits coverage to our Members. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months Go-Live.
6. Plan Design	
Guarantee	The Contractor shall correctly adjudicate claims in accordance with the plan design and State approved covered benefits, see Contract section A.12.a.
Assessment	One hundred dollars ($100) per occurrence (defined as an individual claim) for each incorrectly processed claim.
Justification	Plan design information must be accurate as to not cause confusion or financial hardship to Members. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Reported after each occurrence. Measured, reconciled and assessed quarterly.
7. Website and Splash Page	
Guarantee	The Contractor's website and splash page for the Public Sector Plans shall be available on the internet and fully operational, with the exception of member data/Protected Health Information at least thirty (30) days prior to the first day of annual enrollment (generally October 1)as specified in Contract Section A.15.h.
Assessment	One thousand dollars ($1,000) per Business Day, per site until operational or updated.
Justification	This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live and annually thereafter.
8. Initial and Annual Welcome Packet and ID Card Distribution	
Guarantee	Ninety-five percent (95%) of welcome packets and ID cards shall be produced and mailed no later than fourteen (14) days prior to Go-Live and annually as required in Contract Section A.14.d and A.14.i.
Assessment	Ten thousand dollars ($10,000) if the guarantee is not met.
Justification	This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed no later than three months after Go-Live.
9. Plan Changes	
Guarantee	Unless otherwise directed by the State, the Contractor shall correctly implement any plan design changes annually no later than January 1st of the benefit plan year or within sixty (60) days of written notification from the State for mid-year changes as required in Contract Section A.12.c.

Assessment	Twenty-five thousand dollars ($25,000) per incorrect plan design setup such as, but not limited to, incorrect member cost share, incorrect covered services or excluded services.	
Justification	Plan changes must be timely and accurately implemented as to not cause confusion or financial hardship to Members. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.	
Measurement	Reported after each occurrence. Measured, reconciled and assessed quarterly.	
10. Member Notice of Provider Termination		
Guarantee	The Contractor shall provide written notice to members regarding terminated hospitals and physician groups, as specified in Contract Section A.6.h.	
Assessment	Ten thousand dollars ($10,000) per occurrence (defined as each provider termination) if the guarantee is not met.	
Justification	Members must be notified timely of any provider terminations as to not cause confusion or financial hardship to Members. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.	
Measurement	Reported after each occurrence. Measured, , reconciled and assessed quarterly.	
11. Efficient Network Provider/Facility Network Accessibility		
Guarantee	As measured by the Geographic Access Provider & Facility Network Accessibility Analysis, the Contractor's efficient provider and facility network shall assure that 95% of all State, Local Education, and Local Government Plan enrolled members residing in Tennessee shall have the Access Standard indicated, as required in Contract Section A.6.c and A.6.d.	
Definition	**Provider Group – Urban**	**Access Standard**
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 10 miles
	Obstetricians/Gynecologists	2 physicians within 10 miles
	Pediatricians	2 physicians within 10 miles
	Cardiologists	1 physician within 10 miles
	Endocrinologists	1 physician within 15 miles
	Acute Care Hospitals	1 facility within 10 miles
	Provider Group – Suburban	**Access Standard**
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 15 miles
	Obstetricians/Gynecologists	2 physicians within 15 miles
	Pediatricians	2 physicians within 15 miles
	Cardiologists	1 physician within 15 miles
	Endocrinologists	1 physician within 20 miles
	Acute Care Hospitals	1 facility within 10 miles
	Provider Group – Rural	**Access Standard**

	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 20 miles
	Obstetricians/Gynecologists	2 physicians within 20 miles
	Pediatricians	2 physicians within 20 miles
	Cardiologists	1 physician within 20 miles
	Endocrinologists	1 physician within 30 miles
	Acute Care Hospitals	1 facility within 20 miles
Assessment	Seventy-five thousand dollars ($75,000) if any of the above listed standards is not met, either individually or in combination. For purposes of measuring compliance with the access standards delineated in this liquidated damage, the Contractor shall provide the State with a Geographic Access report of provider access for urban, suburban, and rural areas. Unless otherwise directed by the State, the Contractor shall use the default definitions for urban, suburban, and rural areas. Unless otherwise directed by the State, the Contractor shall use the approved data analysis, report format, and Tennessee ZIP code list provided by the State prior to each reporting period.	
Justification	The Contract requires minimum access standards and without those, Members do not have access to providers within the access standards and therefore the potential to go without medical services and increased financial hardship. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.	
Measurement	Compliance report is the quarterly Geographic Access Analysis submitted by the Contractor. Measured, reported, reconciled, and assessed quarterly.	
12. Broad Network Provider/Facility Network Accessibility		
Guarantee	As measured by the Geographic Access Provider & Facility Network Accessibility Analysis, the Contractor's Broad provider and facility network shall assure that 95% of all State, Local Education, and Local Government Plan enrolled members residing in Tennessee shall have the Access Standard indicated, as required in Contract Section A.6.c and A.6.d.	
Definition	**Provider Group – Urban**	**Access Standard**
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 5 miles
	Obstetricians/Gynecologists	2 physicians within 5 miles
	Pediatricians	2 physicians within 5 miles
	Cardiologists	1 physician within 5 miles
	Endocrinologists	1 physician within 10 miles
	Acute Care Hospitals	1 facility within 5 miles
	Provider Group – Suburban	**Access Standard**
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 10 miles
	Obstetricians/Gynecologists	2 physicians within 10 miles
	Pediatricians	2 physicians within 10 miles

	Cardiologists	1 physician within 10 miles
	Endocrinologists	1 physician within 15 miles
	Acute Care Hospitals	1 facility within 5 miles
	Provider Group – Rural	**Access Standard**
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 15 miles
	Obstetricians/Gynecologists	2 physicians within 15 miles
	Pediatricians	2 physicians within 15 miles
	Cardiologists	1 physician within 15 miles
	Endocrinologists	1 physician within 20 miles
	Acute Care Hospitals	1 facility within 10 miles
Assessment	Seventy-Five thousand dollars ($75,000) if any of the above listed standards is not met, either individually or in combination. For purposes of measuring compliance with the access standards delineated in this liquidated damage, the Contractor shall provide the State with a Geographic access report of provider access for urban, suburban, and rural areas. Unless otherwise directed by the State, the Contractor shall use the default definitions for urban, suburban, and rural areas. Unless otherwise directed by the State, the Contractor shall use the approved data analysis, report format, and Tennessee zip code list provided by the State prior to each reporting period.	
Justification	The Contract requires minimum access standards and without those, Members do not have access to providers within the access standards and therefore the potential to go without medical services and increased financial hardship. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.	
Measurement	Compliance report is the quarterly Geographic access Analysis submitted by the Contractor. Measured, reported, reconciled and assessed quarterly.	
13. Enrollment Set-Up		
Guarantee	As required in Contract Section A.22.d., enrollment information shall be loaded, tested, verified and available online for use no later than thirty (30) days prior to Go-Live.	
Assessment	Ten thousand ($10,000) for each Business Day beyond the date specified in Contract Section A.22.d.	
Justification	Enrollment file set-up is a critical step in providing Members medical benefits. Without the accurate and timely set-up of this file, there is a potential harm to Members financially and in receiving medical services. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.	
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live.	
14. Claims Data Submission		

Guarantee	The Contractor shall submit claims data to the State's DSS vendor no later than fifteen (15) days following the end of each calendar month, or more frequently as directed by the State (see Contract Section A.22.l.1).
Assessment	Five thousand dollars ($5,000) per Business Day up to the twentieth (20th) Business Day.
Justification	Timely submission of claims data ensures that the State and Members have accurate and timely information. The State relies on the claims data information for reporting and planning purposes. Members rely on this data for Plan information such as deducible and out of pocket maximum amounts. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed quarterly.
15. NCQA Accreditation	
Guarantee	The Contractor shall submit a copy of their NCQA Health Plan Accreditation at a level of 4 or more stars as specified in Contract Section A.19.l.
Assessment	Twenty thousand dollars ($20,000) per guarantee that is not met.
Justification	This accreditation sets out minimum standards and measurement that a Contractor must meet to receive NCQA accreditation. This assessment and amount take into account the State's increased oversite and management of the Contractor without this accreditation.
Measurement	Measured, reported, reconciled and assessed annually.
16. Privacy and Security of Protected Health Information Impacting 1 to 499 Members	
Guarantee	In accordance with Contract Section D.20 and Contract Attachment E, the Contractor shall not violate the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act). Pursuant to 45 CFR 164.402, breach is defined as the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI.
Assessment	Four Thousand Eight Hundred dollars ($4,800) per violation until resolved. The guarantee and assessment estimate the impact on the State including the unpredictability of the timing of a breach; specifics of the breach's scope; length of time of investigation completion; number of Member calls to the BA service center; and level of legislative inquiries. ***In the event Contractor is responsible for Federal Penalties related to a Privacy or HIPAA violation, the State may, at their discretion waive any Liquidated Damages due the State in association with the same violation.***
Justification	This assessment is based on the previous experience BA has had in responding to similar incidents impacting less than five hundred (500) Members which includes the following predicted costs to BA: 1. HIPAA Compliance Officer time including investigating the breach, monitoring the HIPAA privacy hotline and email address estimated at seventy-five (75) hours; 2. Director of Financial Management and Program Integrity time and work estimated at seven and half (7.5) hours; 3. Program Director associated with this contract time and work estimated at fifteen (15) hours; 4. Executive Director's time and work estimated at one (1) hour;

	5. Department attorney time including legal review estimated at one (1) hour; and 6. Service Center staff time and work answering Member questions/concerns estimated at fifteen (15) hours
Measurement	Reported after each occurrence. Measured, reconciled and assessed quarterly.
17. Privacy and Security of Protected Health Information Impacting 500 or more Members	
Guarantee	In accordance with Contract Section D.20 and Contract Attachment E, the Contractor shall not violate the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act). Pursuant to 45 CFR 164.402, breach is defined as the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI.
Assessment	Nineteen Thousand dollars ($19,000) per incident basis violation until resolved This assessment is based on the previous experience BA has had in responding to similar incidents impacting five hundred (500) or more Members which includes the following predicted costs to BA: 1. HIPAA Compliance Officer time including investigating the breach, monitoring the HIPAA privacy hotline and email address estimated at one hundred thirty (130) hours; 2. Director of Financial Management and Program Integrity time and work estimated at thirty (30) hours; 3. Program Director associated with this Contract time and work estimated at forty-five (45) hours; 4. Executive Director's time and work estimated at eighteen (18) hours; 5. Department attorney time including legal review estimated at thirty (30) hours; 6. Service Center staff time and work answering Member questions/concerns estimated at one-hundred (100) hours; 7. Public Information Officer ("PIO")'s time and work estimated at forty-five (45) hours; and 8. Communications Director's time and work estimated at thirty (30) hours.
Justification	The guarantee and assessment estimate the impact on the State including the unpredictability of the timing of a breach; specifics of the breach's scope; length of time of investigation completion; number of Member calls to the BA service center; and level of legislative inquiries. A breach impacting five hundred (500) or more Members has additional required steps and procedures including notification to the Office of Civil Rights ("OCR") with the U.S. Department of Health & Human Services ("HSS"); documentation to OCR for a required investigation; the drafting and mailing of Member notification letters; and a federally-required media release to media outlets across the State.
Measurement	Reported after each occurrence. Measured, reconciled and assessed quarterly.

CONTRACT ATTACHMENT C

REPORTING REQUIREMENTS

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

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

1. Weekly reports shall be submitted by Tuesday of the following week;
2. Monthly reports shall be submitted by the 15th of the following month;
3. Quarterly reports shall be submitted by the 20th of the following month;
4. Semi-Annual Reports shall be submitted by the 20th of the following month;
5. Annual reports shall be submitted within sixty (60) days after the end of the calendar year.

Reports shall include:

1. **Geographic Access Report**, submitted quarterly in compliance with contract section A.6.d.
2. **Provider Denied Claim Appeals Report,** submitted quarterly in compliance with contract section A.6.o.
3. **Continuity of Care and Unique Care Exception Report**, submitted monthly in compliance with contract section A.6.x.
4. **CAHPS Survey**, survey results submitted annually by July 20th with the associated corrective action plan in compliance with contract section A.7.n.
5. **Appeals Report**, submitted quarterly in compliance with contract section A.8.g.
6. **URAC Utilization Management Accreditation Certification**, annually in compliance with contract section A.9.b.
7. **Prior Authorization and Utilization Management Report**, submitted quarterly in compliance with contract section A.9.j.
8. **Expert Medical Opinion Report,** submitted monthly in compliance with contract section A.9.r.
9. **Episodes Report**, in compliance with contract section A.10.b.(9).
10. **Value Based Payments Report,** In compliance with contract section A.10.k.(5).
11. **Telehealth Utilization Report,** submitted quarterly in compliance with contract section A.10.m.
12. **Diabetes Prevention Program Outcomes Report,** submitted quarterly in compliance with contract section A.10.n.
13. **Call Center Statistics**, submitted monthly in compliance with contract section A.11.j.
14. **Claims Financial Accuracy Report,** submitted quarterly in compliance with contract section A.12.i.(3).
15. **Processed Claims Report,** submitted quarterly in compliance with contract section A.12.i.(8).
16. **Rebate Report**, submitted quarterly in compliance with contract section A.12.w.
17. **Coordination of Benefits Report**, submitted weekly in compliance with contract section A.12.aa.
18. **Medicare Secondary Payer Report,** submitted weekly in compliance with contract section A.12.bb.
19. **Recoveries Reports**, submitted monthly in compliance with contract section A.12.cc.

20. **Bank Draft Report,** submitted at the same frequency as Contractor's bank drafts in compliance with contract section A.12.gg.(1).
21. **Reconciliation Report**, submitted monthly in a format prior approved by the State in compliance with contract section A.12.gg.(2).
22. **Denied Claims Report,** submitted quarterly in compliance with contract section A.12.ll.
23. **Pended Claims Report,** submitted monthly in compliance with contract section A.12.mm.
24. **Marketing and Communications Report,** submitted semi-annually in compliance with contract section A.13.b.2.
25. **Transparency Tool Report,** submitted quarterly in compliance with contract section A.15.g.(7).
26. **ASP Specialty Drug Reconciliation Report**, submitted annually in compliance with contract sections A.16.f and C.3.g. of this contract and will be validated by the State's actuarial consultant.
27. **Wellness Activity Completion**, submitted at the request of the State in compliance with contract section A.18.c.
28. **NCQA Health Plan Accreditation Certification,** in compliance with contract section A.19.l.
29. **HEDIS Report**, submitted annually by August 15th in compliance with contract section A.19.m.
30. **Ad-Hoc Reports**, in compliance with contract section A.21.e.
31. **Weekly Enrollment File Error Report**, submitted within one (1) Business Day of receipt of the weekly enrollment file in compliance with contract section A.22.e(3).
32. **CMS Data Match Report**, submitted quarterly in compliance with contract section A.22.g this contract.
33. **Local Government CMS Data Match Report**, submitted monthly in compliance with contract section A.22.h.
34. **Security Risk Assessment Results Report**, submitted one (1) month prior to Go-Live and, thereafter, annually in compliance with contract section A.23.i(10).
35. **BC-DR Test Results Summary**, annually in compliance with contract section E.8.d.(3).
36. **SOC 2 Type 2 Report**, submitted by Go-Live and in compliance with contract section E.8.e.
37. **Other Reports**, as specified in this Contract.

CONTRACT ATTACHMENT D

Service Level Agreement Scorecard

Below is the SLA Scorecard and associated KPIs used to measure the Contractor's performance against the desired outcomes. KPIs shall be evaluated, scored, and reconciled quarterly via the SLA Scorecard with relevant documentation. Contractor must submit the SLA Scorecard each calendar quarter documenting the Contractor's outcome for each of the KPI for the previous quarter, in which services were delivered, as well as any At-Risk Performance Payment due (if applicable).

It is agreed by the State and the Contractor that any At-Risk Performance Payment assessed by the State shall be due and payable to the State within forty-five (45) calendar days after Contractor receipt of the Invoice containing an assessment of fees at risk. If payment is not made by the due date, the At-Risk Performance Payment amount may be withheld from future payments by the State without further notice.

Use the following for the quarterly calculations – the Contractor will fill in the Quarterly Score column for each individual KPI. If the individual KPI does not apply for the reported quarter, place 'n/a' in the Quarterly Score column. The total possible score will be adjusted accordingly. The State will calculate the Total Quarterly Score using the following formula: Quarterly Score divided by total possible quarterly score multiplied by 100%. The At Risk Performance Payment will be determined by this percentage (see table below).

KPI		Description	Performance Requirement	Vendor Performance	Score if Met	Quarterly Score
1.	PA and UM Evaluation	The Contractor shall complete ninety-seven percent (97%) of all prior authorizations and utilization management decisions within the timeframes specified in Section A.9.i.	97%	97% or greater 95.0-96.9% 93.0-94.9% Less than 93%	10 8 6 0	
2.	Eligibility Discrepancies	Resolve all eligibility discrepancies (any difference of values between the State's database and the Contractor's database), not identified during processing, as identified by the State or Contractor within one (1) business day of notification by the State or identification by the Contractor, as required in Contract Section A.22.e.4.	100%	100% 98.0-99.9% 96.0-97.9% Less than 96%	10 8 6 0	
3.	Expedited Appeals	One hundred percent (100%) of expedited appeals for urgent care, not involving a third-party review, shall be decided within seventy-two (72) hours, as required in Contract Section A.8.f.1.	100%	100% 98.0-99.9% 96.0-97.9% Less than 96%	10 8 6 0	

4.	Non-Urgent Pre-Service Appeals	Ninety-five percent (95%) of non-urgent pre-service appeals shall be decided within thirty (30) days, as required in Contract Section A.8.f.2.	95%	95% or greater 93.0-94.9% 91.0-92.9% Less than 91%	8 6 4 0	
5.	Non-Urgent Post-Service Appeals	Ninety-five percent (95%) of non-urgent post-service appeals within sixty (60) days, as required in Contract Section A.8.f.3.	95%	95% or greater 93.0-94.9% 91.0-92.9% Less than 91%	8 6 4 0	
6.	Claims Auto-Adjudication	The claims management system shall automatically adjudicate no less than eighty percent (80%) of clean claims, i.e., without recourse to manual or other calculation methods external to the system, as required in Contract Section A.12.i.1.	80%	80% or greater 75.0-79.9% 70.0-74.9% Less than 70%	8 6 4 0	
7.	Claim Adjustment Completion	The Contractor shall complete ninety-five percent (95%) of all claim adjustments within seven (7) calendar days, as required in Contract Section A.12.i.6.	95%	95% or greater 93.0-94.9% 91.0-92.9% Less than 91%	8 6 4 0	
8.	Average Speed of Answer	The Contractor shall maintain an average daily ASA of thirty (30) seconds and callers may not be placed on hold after the call is answered, as required in Contract Section A.11.i.1.	30 second average	30 Sec Avg 29-29.9 Sec Avg 28-28.9 Sec Avg Less than 28 Sec Avg	8 6 4 0	
9.	First Call Resolution	The Contractor shall maintain a first call resolution rate of 85%, as required in Contract Section A.11.i.2.	85%	85% or greater 83.0-84.9% 81.0-82.9% Less than 81%	8 6 4 0	
10.	Distribution of Ongoing Member ID Cards/Welcome Packets	Ninety-five percent (95%) of new member welcome packets and ID cards shall be produced and mailed within ten (10) days of receipt of complete and accurate eligibility information, as required in Contract Section A.14.e.	95%	95% or greater 93.0-94.9% 91.0-92.9% Less than 91%	10 8 6 0	

Total Sum Available Quarterly Scores	
Total Sum Achieved Quarterly Scores	
Quarterly Calculated Performance Percentage (Total Sum Achieved Quarterly Scores/ Total Sum of Available Quarterly Scores for all applicable KPIs) *100	

Quarterly Calculated Performance Percentage	At Risk Performance Payment
>=96%	0% of previous quarter Administrative Fees
91 – 95%	.25% of previous quarter Administrative Fees
86 – 90%	.50% of previous quarter Administrative Fees
81 - 85%	.75% of previous quarter Administrative Fees
76 – 80%	1% of previous quarter Administrative Fees
71 – 75%	1.5% of previous quarter Administrative Fees
66 – 70%	2% of previous quarter Administrative Fees
61 – 65%	3% of previous quarter Administrative Fees
<61%	4% of previous quarter Administrative Fees

KPI	Description	Performance Requirement	At Risk Performance Payment
Unauthorized Usage of Information	Unless prior approved In Writing by the State, and in compliance with state and federal law, the Contractor shall not use information gained through this Contract, including but not limited to utilization and pricing information, in marketing or expanding non-State business relationships or for any pecuniary gain as stated in Contract Section A.4.l.	If the Contractor uses data without prior approval	$50,000 per incident.
Reporting	The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract as required in Contract Section A.21.a, A.21.g.7., and Contract Attachment C, Reporting Requirements.	If the Contractor fails to deliver any report on time.	$1,000 per late or undelivered report.
Claims Payment Accuracy	Claims payment accuracy shall be ninety-seven point five percent (97.5%) or higher as required in Contract Section A.12.i.5. • Quarterly internal audit performed by the State on a sample of 175 incurred date claims and 175 different paid date claims selected at random and provided by the Contractor. • Measures the frequency of payment errors by dividing the weighted number of correct benefit payments by the total number of payments in the population.	If the Contractor fails to meet the requirement.	$5,000 per missed requirement.
Claims Payment Turnaround	The Contractor shall reimburse network providers within fourteen (14) calendar days for ninety-two percent (92%) of clean claims	If the Contractor fails to meet	$5,000 per each missed requirement.

	and within thirty (30) calendar days for ninety-eight percent (98%) of all claims as required in Contract Section A.12.i.2. • Quarterly internal audit performed by the State on a sample of 175 incurred date claims and 175 different paid date claims selected at random and provided by the Contractor. • Measures the time elapsed from the date a claim is received to the date the claim is processed. Only the received date, not the processed date is included in the calculation.	either requirement.	
Claims Processing Accuracy	Claims processing accuracy shall be ninety-six percent (96%) or higher as required in Contract Section A.12.i.4. • Quarterly internal audit performed by the State on a sample of 175 incurred date claims and 175 different paid date claims selected at random and provided by the Contractor. • Measured by dividing the weighted number of claims processed without any type of error by the total number of claims in the population.	If the Contractor fails to meet the requirement.	$5,000 per missed requirement.
Financial Accuracy	Financial accuracy shall be ninety-nine percent (99%) or higher as required in Contract Section A.12.i.3. • Quarterly internal audit performed by the Contractor on a statistically valid sample. • Calculated by taking the total benefit dollars paid in the population, minus the sum of the weighted absolute value of overpayments and underpayments identified from the sample, divided by the total dollars paid in the population.	If the Contractor fails to meet the requirement.	$5,000 per missed requirement.
Claims Data Quality	As assessed by the State's DSS contractor, the Contractor's data submission to the DSS contractor shall meet the following measures as required in Contract Section A.22.l.(3). Measures and Benchmarks: • Gender Data missing for </= (less than or equal to) 3% of claims • Date of birth Data missing for </= 3% of claims • Outpatient diagnosis coding Data invalid or missing for </= 5% of outpatient claims • Outpatient provider type missing Data missing for </= 1.5% of outpatient claims • Provider ID missing Data missing for </= 1.5% of claims	If the Contractor fails to meet any requirement.	$5,000 if any requirement is missed

Member Satisfaction Survey	The level of overall customer satisfaction, as measured annually by the CAHPS Member Satisfaction survey(s) required by Contract Section A.7.n., shall be equal to or greater than eighty-five percent (85%) in the first year of the Contract, and shall be equal to or greater than ninety percent (90%) in all subsequent year(s) within the contract term.	If the Contractor fails to meet the requirement.	$20,000 for each instance.
Authorization of Member Communications	The Contactor shall not distribute any materials to members prior to receiving the express, written authorization by the State for the use of such materials as required in Contract Section A.13.c and A.13.i..	If the Contractor distributes materials without prior State approval, In Writing.	$25,000 for each instance.
Timely Notification	The Contractor shall notify the State, within three (3) business days of identification, about any situation that appears to negatively impact the administration or delivery of the program, plan, or benefits including but not limited to file and data sharing between contractors, as required in Contract Section A.4.n.	If the Contractor fails to notify the State within three (3) Business Days	$10,000 per incident.

Contract Attachment E

HIPAA BUSINESS ASSOCIATE AGREEMENT
COMPLIANCE WITH PRIVACY AND SECURITY RULES

THIS BUSINESS ASSOCIATE AGREEMENT (hereinafter "Agreement") is between **The State of Tennessee, Finance and Administration, Division of Benefits Administration** (hereinafter "Covered Entity") and _____ (hereinafter "Business Associate"). Covered Entity and Business Associate may be referred to herein individually as "Party" or collectively as "Parties."

BACKGROUND

Parties acknowledge that they are subject to the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act), in certain aspects of its operations.

Business Associate provides services to Covered Entity pursuant to one or more contractual relationships detailed below and hereinafter referred to as "Service Contracts."

LIST OF AGREEMENTS AFFECTED BY THIS BUSINESS ASSOCIATE AGREEMENT:

Contract Name:	**Execution Date:**
_____	_____

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

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

DEFINITIONS

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 CFR §§ 160.103, 164.103, 164.304, 164.402, 164.501, and 164.504.

1.1 "Breach of the Security of the [Business Associate's Information] System" shall have the meaning set out in its definition at T.C.A. § 47-18-2107

1.2 "Business Associate" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.3 "Covered Entity" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

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

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

1.6 "Genetic Information" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

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

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

1.9 "Information Holder" shall have the meaning set out in its definition at T.C.A. § 47-18-2107

1.10 "Marketing" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.11 "Personal information" shall have the meaning set out in its definition at T.C.A. § 47-18-2107

1.12 "Privacy Official" shall have the meaning as set out in its definition at 45 C.F.R. § 164.530(a)(1).

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

1.14 "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

1.15 "Required by Law" shall have the meaning set forth in 45 CFR § 164.512.

1.16 "Security Incident" shall have the meaning set out in its definition at 45 C.F.R. § 164.304.

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

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

2.1 Business Associate is authorized to use PHI for the purposes of carrying out its duties under the Services Contract. In the course of carrying out these duties, including but not limited to carrying out the Covered Entity's duties under HIPAA, 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 Contracts, or as Required By Law. Business Associate is subject to requirements of the Privacy Rule as required by Public Law 111-5, Section 13404 [designated as 42 U.S.C. 17934] In case of any conflict between this Agreement and the Service Contracts, this Agreement shall govern.

2.2 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 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 Associate shall use appropriate administrative, physical, and technical safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement, Services Contract(s), 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. 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.

2.4 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 information, to agree, by written contract with Business Associate, in accordance with 164.502(e)(1)(ii), ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of business associate agree to the same restrictions and conditions that apply to the business associate with respect to such information.

2.5 Business Associate shall 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.

2.6 Business Associate shall require its employees, agents, and subcontractors to promptly (up to 48 hours) report, to Business Associate, immediately upon becoming aware of any use or disclosure of PHI in violation of this Agreement. Business Associate shall report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement. Business Associate will also provide additional information reasonably requested by the Covered Entity related to the breach.

2.7 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.

2.7.1 Business Associate shall provide to Covered Entity notice of a Potential or Actual Breach of Unsecured PHI immediately upon becoming aware of the Breach.

2.7.2 Business Associate shall cooperate with Covered Entity in timely providing the appropriate and necessary information to Covered Entity.

2.7.3 Covered Entity shall make the final determination whether the Breach requires notification and whether the notification shall be made by Covered Entity or Business Associate.

2.8 If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate shall provide access, at the request of Covered Entity, to PHI in a Designated Record Set to Covered Entity, in order to meet the requirements under 45 CFR § 164.524, provided that Business Associate shall have at least 30 Business days from Covered Entity notice to provide access to, or deliver such information.

2.9 If Business Associate receives PHI from Covered Entity in a Designated Record Set, then Business Associate shall make any amendments to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to the 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity, provided that Business Associate shall have at least 30 business days from Covered Entity notice to make an amendment.

2.10 Business Associate shall make its internal practices, books, and records including policies and 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 Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule.

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

2.12 Business Associate shall provide Covered Entity or an Individual, in time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for and accounting of disclosures of PHI in accordance with 45 CFR § 164.528, provided that Business Associate shall have at least 30 business days from Covered Entity

notice to provide access to, or deliver such information which shall include, at minimum, (a) date of the disclosure; (b) name of the third party to whom the PHI was disclosed and, if known, the address of the third party; (c) brief description of the disclosed information; and (d) brief explanation of the purpose and basis for such disclosure. Business Associate shall provide an accounting of disclosures directly to an individual when required by section 13405(c) of Public Law 111-5 [designated as 42 U.S.C. 17935(c)].

2.13 Business Associate agrees it must 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.

2.13.1 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.

2.13.2 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.

2.13.3 Business Associate acknowledges that if Business Associate is also a covered entity, as defined by the Privacy Rule, Business Associate is required, independent of Business Associate's obligations under this Memorandum, to comply with the Privacy Rule's minimum necessary requirements when making any request for PHI from Covered Entity.

2.14 Business Associate shall adequately and properly maintain all PHI received from, or created or received on behalf of, Covered Entity

2.15 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 and notify the Covered Entity of such action. If Business Associate receives a request for PHI 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 notify Covered Entity of such request and forward the request to Covered Entity. Business Associate shall then assist Covered Entity in responding to the request.

2.16 Business Associate shall fully cooperate in good faith with 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 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 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 and Public Law 111-5. 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 to certify its compliance with the Security Rule.

3.3 Business Associate shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI received from 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, to agree, by written contract (or the appropriate equivalent if the agent is a government entity) with Business

Associate, in accordance with 164.502(e)(1)(ii), ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of business associate agree to the same restrictions and conditions that apply to the business associate with respect to such information.

3.4 Business Associate shall require its employees, agents, and subcontractors to report to Business Associate within five (5) business days, any Security Incident (as that term is defined in 45 CFR § 164.304) of which it becomes aware. 45 CFR 164.314(a)(2)(C) requires that business associate shall report to the covered entity any security incident of which is becomes aware, including breaches of unsecured protected health information as required by 164.410. Business Associate shall promptly (up to 48 hours) report any Security Incident of which it becomes aware to Covered Entity. Provided however, that such reports are not required for attempted, unsuccessful Security Incidents, including trivial and routine incidents such as port scans, attempts to log-in with an invalid password or user name, denial of service attacks that do not result in a server being taken off-line, malware, and pings or other similar types of events.

3.5 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 Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Security Rule.

3.6 Business Associate shall fully cooperate in good faith with and to assist Covered Entity in complying with the requirements of the Security Rule.

3.7 Notification for the purposes of Sections 2.7.1 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:

State of Tennessee
Benefits Administration
HIPAA Privacy & Security Officer
312 Rosa L. Parks Avenue
1900 W.R.S. Tennessee Towers
Nashville, TN 37243-1102
Phone: (615) 770-6949
Facsimile: (615) 253-8556

With a copy to:

State of Tennessee
Benefits Administration
Contracting and Procurement Director
312 Rosa L. Parks Avenue
1900 W.R.S. Tennessee Towers
Nashville, TN 37243-1102
Phone: (615) 532-4598
Facsimile: (615) 253-8556

3.8 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 the key contact during the term of this Agreement In Writing within ten (10) business days.

4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in Service Contract(s), provided that such use or disclosure would not violate the Privacy and Security Rule, if done by Covered Entity. Business Associate's disclosure of PHI shall be subject to the limited data set and minimum necessary requirements of Section 13405(b) of Public Law 111-5, [designated as 42 U.S.C. 13735(b)]

4.2 Except as otherwise limited in this Agreement, Business Associate may use PHI as required for Business Associate's proper management and administration or to carry out the legal responsibilities of the Business Associate.

4.3 Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or 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 Except as otherwise limited in this Agreement, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 45 CFR § 164.504(e)(2)(i)(B).

4.5 Business Associate may use PHI to report violations of law to appropriate Federal and State Authorities consistent with 45 CFR 164.502(j)(1).

4.6 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 member's personal or financial information with affiliates, even if such sharing would be permitted by federal or state laws, is prohibited.

4.7 Business Associate shall enter into written agreements that are substantially similar to this Business Associate Agreement with any Subcontractor or agent which Business Associate provides access to Protected Health Information.

4.8 Business Associates shall implement and maintain information security policies that comply with the HIPAA Security Rule.

5. OBLIGATIONS OF COVERED ENTITY

5.1 Covered Entity shall provide Business Associate with the Notice of Privacy Practices that Covered Entity produces in accordance with 45 CFR § 164.520, as well as any changes to such notice. Covered Entity shall notify Business Associate of any limitations in its notice that affect Business Associate's use or disclosure of PHI.

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

6. PERMISSIBLE REQUESTS BY COVERED ENTITY

6.1 Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy or Security Rule, if done by Covered Entity.

7. TERM AND TERMINATION

7.1 Term. The Term of this Agreement shall be effective as of June 1, 2021 and shall terminate on June 30, 2029 as referenced Contract Sections A.24.e. and D.11 or on the date covered entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.

7.2 Termination for Cause.

7.2.1. This Agreement authorizes and Business Associate acknowledges and agrees Covered Entity shall have the right to immediately terminate this Agreement and Service Contracts in the event Business Associate fails to comply with, or violates a material provision of, requirements of the Privacy and/or Security Rule or this Memorandum.

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

7.2.2.1. Provide a reasonable opportunity for Business Associate to cure the breach or end the violation, or

7.2.2.2. If Business Associate has breached a material term of this Agreement and cure is not possible or if Business Associate does not cure a curable breach or end the violation within a reasonable time as specified by, and at the sole discretion of, Covered Entity, Covered Entity may immediately terminate this Agreement and the Service Agreement.

7.2.2.3. If neither cure nor termination is feasible, Covered Entity shall report the violation to the Secretary of the United States Department of Health in Human Services or the Secretary's designee.

7.3 Effect of Termination.

7.3.1 Upon termination of this Agreement for any reason, business associate, with respect to protected health information received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, shall:

1. Retain only that protected health information which is necessary for business associate to continue its proper management and administration or to carry out its legal responsibilities;

2. Return to covered entity [or, if agreed to by covered entity, destroy and provide a Certificate of Destruction] the remaining protected health information that the business associate still maintains in any form;

3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the

protected health information, other than as provided for in this Section, for as long as business associate retains the protected health information;

4. Not use or disclose the protected health information retained by business associate other than for the purposes for which such protected health information was retained and subject to the same conditions set out at [Insert section number related to paragraphs under "Permitted Uses and Disclosures By Business Associate"] which applied prior to termination; and

5. Return to covered entity [or, if agreed to by covered entity, destroy and provide Certificate of Destruction] the protected health information retained by business associate when it is no longer needed by business associate for its proper management and administration or to carry out its legal responsibilities.

8. MISCELLANEOUS

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

8.2 Amendment. The Parties agree to take such action as is necessary 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, including any amendments required by the United States Department of Health and Human Services to implement the Health Information Technology for Economic and Clinical Health and related regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended, including, but not limited to changes required by the American Recovery and Reinvestment Act of 2009, Public Law 111-5.

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

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

8.5 Notices and Communications. All instructions, notices, consents, demands, or other communications required or contemplated by this Agreement shall be In Writing and shall be delivered by hand, by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below, or to such other party, facsimile number, or address as may be hereafter specified by written notice.

COVERED ENTITY:
State of Tennessee
Department of Finance and Administration
Benefits Administration
ATTN: Chanda Rainey
HIPAA Privacy & Security Officer
312 Rosa L. Parks Avenue
1900 W.R.S. Tennessee Towers
Nashville, TN 37243-1102
Phone: (615) 770-6949
Facsimile: (615) 253-8556
E-Mail: benefits.privacy@tn.gov

With a copy to:
ATTN: Seannalyn Brandmeir

BUSINESS ASSOCIATE:

Procurements & Contracting Director
At the address listed above
Phone: (615) 532-4598
Facsimile: (615) 253-8556
E-Mail: seannalyn.brandmeir@tn.gov

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

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

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

8.8 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.

8.9 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 contracts referenced herein.

8.10 Security Breach A violation of HIPAA or the Privacy or Security Rules constitutes a breach of this Business Associate Agreement and a breach of the Service Contract(s) listed on page one of this agreement, and shall be subject to all available remedies for such breach.

IN WITNESS WHEREOF,

_____

Date:

_____

Howard H. Eley, Commissioner of Finance & Administration **Date:**