

**CONTRACT # 1677-DLTC-XXX FOR
STATEWIDE LONG-TERM CARE INFRASTRUCTURE
THIRD PARTY ADMINISTRATION**

BETWEEN THE
STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
AND

XX

This Contract is between the Department of Health Services ("Department"), acting in support of the Managed Care Organizations providing program delivery services for the Family Care and Family Care Partnership programs, and _____ ("Contractor"), effective on 02/26/2010 ("Effective Date"). The Contract period will run for five (5) years from the Effective Date with an option to renew for two (2) additional two-year periods upon mutual agreement of the Parties.

This Contract embodies the entire agreement between the Department and Contractor on the matters specified herein, whether expressed or implied, written or oral. No changes, amendments, or modifications of any of the terms or conditions of this Contract are valid unless reduced to writing and signed by both Parties. The Contractor will enter into a supplemental Participating Agreement with each Managed Care Organization desiring to use Contractor's services.

The Department of Health Services Request for Proposal # 1677-DLTC-PM ("RFP") and the Contractor's RFP response ("Proposal") are incorporated into this Contract as if they had been set forth in their entirety. In the event conflicts or disputes arise over issues not specifically addressed in this Contract, the following documents shall be used to resolve such conflicts or disputes in the following order of precedence:

1. This Contract including all Appendices.
2. The RFP.
3. Contractor's Proposal in response to the RFP.
4. The State's Standard Terms and Conditions and Supplement to the Standard Terms and Conditions, attached to the RFP.

IN WITNESS WHEREOF, the Parties hereto by their duly authorized representatives have executed this Contract with full knowledge of and agreement with the terms and conditions of this Contract.

STATE OF WISCONSIN, DEPARTMENT
OF HEALTH SERVICES

(CONTRACTOR COMPANY NAME)

BY: _____

BY: _____

Name: Fredi-Ellen Bove

Name: _____

TITLE: Deputy Administrator,
Division of Long Term Care

TITLE: _____

DATE: _____

DATE: _____

1.0 SCOPE AND PURPOSE

The Contract sets the terms and conditions for Contractor's third-party administration services to the managed care organizations ("MCOs") in the Family Care and Family Care Partnership programs. Each MCO desiring to use the Contractor's services will sign a Participating Agreement with optional additional terms agreed to between the MCO and the Contractor that are not in conflict with this Contract. The Department does not guarantee any certain level of work arising out of this Contract and Contractor specifically acknowledges that none may result.

2.0 DEFINITIONS

2.1 Participating Agreement means an agreement between the Contractor and an MCO that has been approved by the Department and that incorporates the terms of this Contract and that may include additional terms and services as long as those additional terms do not conflict with this Contract.

2.2 Proposal means the Contractor's proposal, as revised and clarified, in response to RFP #1677-DLTC-PM but not including any exceptions that the Contractor may have taken to the proposed contract in the RFP.

2.3 RFP means Request for Proposal # 1677-DLTC-PM and its attachments, as revised and clarified throughout the procurement process.

3.0 CONTRACT TERMS AND CONDITIONS

3.1 ADMINISTRATION OF AGREEMENTS. The Department will be responsible for interpreting and enforcing the terms of this Contract. The Department will notify the MCOs when the Contractor has met all initial requirements in this Contract and is then available to enter into a Participating Agreement with the MCO.

The Department will be responsible for reviewing a proposed Participating Agreement to ensure that its terms and conditions do not conflict with the terms and conditions of this Contract. Once approved, the MCO will be responsible for interpreting and enforcing the terms of the Participating Agreement and in managing the day-to-day services provided by the Contractor.

Should the MCO and the Contractor fail to resolve any disputes that arise between them regarding the services to be performed under this Contract or under a Participating Agreement, either party may appeal to the Department which will have the authority to render the final administrative decision.

3.2 CONTRACT MANAGER. The Department of Health Services interim Contract Manager for this Contract is Greg Robbins. All contract-related correspondence is to be made via email to Greg.Robbins@wisconsin.gov.

3.3 NOTIFICATION. Either Party may give written notice to the other Party in accordance with the terms of this section. Any notice required or permitted to be given hereunder shall be deemed to have been given on the date of delivery by personal service or hand delivery or three (3) business days after being mailed.

To the Department:

Greg Robbins
Department of Health Services
1 W. Wilson Street, Room B150
P.O. Box 7850
Madison, WI 53707-7850
Telephone: (608)266-5725

To Contractor:

Name _____
Address _____
City, State, Zip _____
Telephone: _____

3.4 CONTRACT SERVICES. The Contractor acknowledges that its services must be consistent with the obligations imposed on the MCO under the contract the MCO has with the Department. If the Department amends the MCO contract in a way that affects the Participating Agreement, the Contractor agrees to amend the Participating Agreement accordingly. The Contractor shall:

3.4.1 Provide the core services for the MCO in the Family Care program in accordance with Section 4.0 of the RFP.

3.4.2 Provide the core services for the MCO in the Family Care Partnership program in accordance with Sections 4.0 and 5.0 of the RFP.

3.4.3 Provide the optional services identified in Sections 4.0 and 5.0 beginning on the implementation date mutually agreed upon by the Department and the contractor, if the Department authorizes the offering of these optional services.

3.4.4 Develop an operating manual in cooperation with the MCO with which it has a Participating Agreement that will provide in more detail the services it will perform for the MCO. The operating manual will become a part of the Participating Agreement and enforceable as such.

3.4.5 Appoint a contract administrator for liaison and consultation with the Department and MCO. The Contract Administrator shall have authority to make managerial and technical decisions concerning the services performed.

3.4.6 Develop and implement a written communications protocol, to be approved by the Department, regarding communications that will occur between the Department, the Contractor, and the MCOs, and the reporting that will be required.

3.4.7 All services provided under this section 3.4 will be provided in accordance with Appendix A. If a provision in Appendix A is not consistent with Section 4.0 or Section 5.0 of the RFP, Appendix A will prevail.

3.5 PAYMENT

3.5.1 The Department will be responsible for paying the Contractor for bulletin level development and bulletin level setup costs, as specified in Appendix B. Bulletin level contracting costs will not be paid to a Contractor by the Department until an MCO level Participating Agreement has been negotiated with that Contractor.

3.5.2 The MCO will be responsible for directly paying the Contractor for all organization level contracting, optional functions contracting, and per member per month service costs provided under this Contract, as specified in Appendix B, and any additional services provided under the Participating Agreement.

3.5.3 Upon receipt of an invoice that is submitted in accordance with the process described in the Participating Agreement, the MCO will pay the Contractor at the rates and charges set in Appendix B.

NOTE: Establishment of the additional business system costs for Family Care Partnership is dependent on an evaluation of policies regarding pharmacy rebates by the Department. A contract addendum will be negotiated to establish this cost, once the Department evaluation is complete.

3.6 CONFIDENTIALITY. The Contractor will be required to enter into a Business Associate Agreement under the Health Insurance Portability and Accountability Act of 1996 with each MCO with which it has a Participating Agreement.

This section is in addition to the responsibilities and obligations imposed on the Contractor through the Business Associate Agreement (“BAA”) with the MCO. In the event of a conflict between this section and the BAA, the BAA will have precedence.

3.6.1 Definitions:

"Confidential Information" means all tangible and intangible information and materials accessed or disclosed in connection with this Contract, in any form or medium (and without regard to whether the information is owned by Contractor, the Department, the MCO or by a third party), that satisfy at least one of the following criteria: (i) Personally Identifiable Information; (ii) Individually Identifiable Health Information; (iii) non-public information related to Contractor's, the Department's or the MCO's employees, customers, technology (including data bases, data processing and communications networking systems), schematics, specifications, and all information or materials derived therefrom or based thereon; or (iv) information designated as confidential in writing by Contractor, the Department or the MCO.

"Individually Identifiable Health Information" means information that relates to the past, present, or future physical or mental health or condition of the individual, or that relates to the provision of health care in the past, present or future, and that is combined with or linked to any information that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

"Personally Identifiable Information" means an individual's last name and the individual's first name or first initial, in combination with and linked to any of the following elements, if the element is not publicly available information and is not encrypted, redacted, or altered in any manner that renders the element unreadable: (a) the individual's Social Security number; (b) the individual's driver's license number or state identification number; (c) the individual's date of birth; (d) the number of the individual's financial account, including a credit or debit card account number, or any security code, access code, or password that would permit access to the individual's financial account; (e) the individual's DNA profile; or (f) the individual's unique biometric data, including fingerprint, voice print, retina or iris image, or any other unique physical characteristic.

"Corrective Action Plan" means a plan communicated by the Department or MCO to the Contractor for the Contractor to follow, or communicated by Contractor to the Department for the Department to follow, in the event of any threatened or actual use or disclosure of any Confidential Information that is not specifically authorized by this Contract, or in the event that any Confidential Information is lost or cannot be accounted for by a Party.

3.6.2 Duty of Non-Disclosure and Security Precautions

Neither Party shall use Confidential Information for any purpose other than the limited purposes set forth in this Contract. Other than as required by law, each Party shall hold the Confidential Information in confidence, and shall not disclose such Confidential Information to any persons other than those directors, officers, employees, and agents ("Representatives") who have a business-related need to have access to such Confidential Information in furtherance of the limited purposes of this Contract and who have been apprised of, and agree to maintain, the confidential nature of such information in accordance with the terms of this Contract. Each Party shall be responsible for the breach of this Contract by any of its Representatives.

Each Party shall institute and/or maintain such procedures as are reasonably required to maintain the confidentiality of the Confidential Information, and shall apply the same level of care as it employs to protect its own confidential information of like nature.

Each Party shall ensure that all indications of confidentiality contained on or included in any item of Confidential Information shall be reproduced by it on any reproduction, modification, or translation of such Confidential Information. If requested by a Party or the MCO, the other Party shall make a reasonable effort to add a proprietary notice or indication of confidentiality to any tangible materials within its possession that contain Confidential Information of the Party or MCO, as directed.

If requested by the Department or MCO, Contractor shall return or destroy all Individually Identifiable Health Information and Personally Identifiable Information it holds upon termination of this Contract. If the Contractor believes that the return or destruction of this information is not feasible, and the Department or MCO agrees, the Contractor shall extend the protections of this Contract to the retained information and prohibit further uses or disclosures without the express

written authorization of the Department or MCO. Subsequent use or disclosure of any information subject to this provision will be limited to the use or disclosure that makes return or destruction not feasible.

3.6.3 Limitations on Obligations

The obligations of confidentiality assumed by each Party pursuant to this Contract shall not apply to the extent the Party can demonstrate that such information:

1. is part of the public domain without any breach of this Contract by the Party;
2. is or becomes generally known on a non-confidential basis, through no wrongful act of the Party;
3. was known by the Party prior to disclosure hereunder without any obligation to keep it confidential;
4. was disclosed to it by a third party which, to the best of the Party's knowledge, is not required to maintain its confidentiality;
5. was independently developed by the Party; or
6. is the subject of a written agreement whereby the other Party or MCO consents to the disclosure of such Confidential Information by the Party or MCO on a non-confidential basis.

3.6.4 Legal Disclosure

If a Party or any of its Representatives shall be under a legal obligation in any administrative, regulatory or judicial circumstance to disclose any Confidential Information, the Party shall give the other Party, or MCO, if applicable, prompt notice thereof (unless it has a legal obligation to the contrary) so that the other Party or MCO may seek a protective order or other appropriate remedy. In the event that such protective order is not obtained, the Party and its Representatives shall furnish only that portion of the information that is legally required and shall disclose the Confidential Information in a manner reasonably designed to preserve its confidential nature.

3.6.5 Unauthorized Use, Disclosure, or Loss

If a Party becomes aware of any threatened or actual use or disclosure of any Confidential Information that is not specifically authorized by this Contract, or if any Confidential Information is lost or cannot be accounted for, the Party shall notify the other Party's or MCO's contract manager within the same business day the Party becomes aware of such use, disclosure, or loss. Such notice shall include, to the best of the Party's knowledge at that time, the persons affected, their identities, and the Confidential Information disclosed.

Each Party shall take immediate steps to mitigate any harmful effects of the unauthorized use, disclosure, or loss. The Party shall reasonably cooperate with the other's efforts to seek appropriate injunctive relief or otherwise prevent or curtail such threatened or actual breach, or to recover its Confidential Information, including complying with a reasonable Corrective Action Plan.

If the unauthorized use, disclosure, or loss is of Personally Identifiable Information, or reasonably could otherwise identify individuals, the Party shall, at

its own cost, take any or all of the following measures that are directed by the other Party or MCO as part of a Corrective Action Plan:

1. Notify the affected individuals by mail or the method previously used by the other Party or MCO to communicate with the individual. If the Party cannot with reasonable diligence determine the mailing address of the affected individual and the other Party or MCO has not previously contacted that individual, the Party shall provide notice by a method reasonably calculated to provide actual notice.
2. Notify consumer reporting agencies of the unauthorized release.
3. Offer credit monitoring and identity theft insurance to affected individuals from a company, and under terms, acceptable to the other Party or MCO for one year from the date the individual enrolls in credit monitoring.
4. Provide a customer service or hotline to receive telephone calls and provide assistance and information to affected individuals during hours that meet the needs of the affected individuals, as established by the other Party or MCO.
5. Adequately staff customer service telephone lines to assure an actual wait time of less than five (5) minutes for callers.

If the unauthorized use, disclosure, or loss is of Individually Identifiable Health Information, the Party shall, at its own cost, notify the affected individuals by mail or the method previously used by the other Party or MCO to communicate with the individual. If the party cannot with reasonable diligence determine the mailing address of the affected individual and the other Party or MCO has not previously contacted that individual, the Party shall provide notice by a method reasonably calculated to provide actual notice. In addition, the Party will take other reasonable measures as are directed by the other Party or MCO as part of a Corrective Action Plan.

3.6.6 Liquidated Damages: Equitable Relief: Indemnification

Indemnification. In the event of a breach of this section by a Party and to the extent permitted by law, the Party shall indemnify and hold harmless the other Party and any of its officers, employees, or agents from any claims arising from the acts or omissions of the Party, and its subcontractors, employees and agents, in violation of this section, including but not limited to costs of monitoring the credit of all persons whose Confidential Information was disclosed, disallowances or penalties from federal oversight agencies, and any court costs, expenses, and reasonable attorney fees, incurred in the enforcement of this section. In addition, notwithstanding anything to the contrary herein and as permitted by law, the Party shall compensate the other Party for its actual staff time and other costs associated with the other Party's response to the unauthorized use or disclosure constituting the breach, including the actual staff time in monitoring the other Party's compliance with the Corrective Action Plan.

Equitable Relief. Each Party acknowledges and agrees that the unauthorized use, disclosure, or loss of Confidential Information may cause immediate and irreparable injury to the individuals whose information is disclosed and to the other Party, which injury will not be compensable by money damages and for which there is not an adequate remedy available at law. Accordingly, the parties specifically agree that the other Party, on its own behalf or on behalf of the affected individuals, shall be entitled to obtain injunctive or other equitable relief

to prevent or curtail any such breach, threatened or actual, without posting security and without prejudice to such other rights as may be available under this Contract or under applicable law.

Liquidated Damages. The Contractor agrees that its failure to take corrective action in response to an unauthorized use or disclosure of Confidential Information may result in damage to the Department's reputation and ability to serve the public interest in its administration of programs affected by this Contract. Such amounts of these damages which will be sustained are not calculable with any degree of certainty and thus shall be in the amount of \$1000 per day for each day that the Contractor fails to substantially comply with the Corrective Action Plan under Section 3.6.5. Assessment under this provision is in addition to other remedies under this Contract, in particular the remedies in the *Indemnification* paragraph of this Section 3.6.6, and as provided in law or equity. The Department shall notify the Contractor in writing of the assessment.

3.6.7 Compliance Reviews

The Department or MCO may conduct a compliance review of the Contractor's security procedures to protect Confidential Information under Section 3.14, Examination of Records, of this Contract.

3.6.8 Survival

This Section 3.6 shall survive the termination of this Contract.

3.7 TERMINATION

3.7.1 Termination for Cause. The Department may terminate this Contract if Contractor does not cure a failure to perform under this Contract within thirty (30) days after written notice by the Department of the failure. The Department also may terminate this Contract, without providing an opportunity to cure, if the Contractor:

- fails to follow the sales and use tax certification requirements of s. 77.66, Wis. Stats.
- has a delinquent Wisconsin tax liability;
- fails to follow the non-discrimination or affirmative action requirements of subch. II, Chapter 111 of the Wisconsin Statutes (Wisconsin's Fair Employment Law);
- is or becomes a federally debarred contractor;
- is presently identified on the list of parties excluded from federal or state procurement and non-procurement contracts;
- fails to maintain and keep in force all required insurance, permits or licenses required in this Contract; or
- fails to maintain the State's Confidential Information; or
- files a petition in bankruptcy, becomes insolvent, or otherwise takes action to dissolve as a legal entity.

In the event of a termination, the MCO will only be liable for payments for services performed prior to the date of termination.

3.7.2 Termination for Non-Cause. Subject to section 3.8, either party may terminate the Contract at any time, without cause, by providing a written notice at least 120 days in advance of the intended date of termination. In the event of termination, the MCO will only be liable for payments for services performed prior to the date of termination.

The Department may terminate the Contract, without penalty and with whatever notice is reasonably possible, if state or federal authority or funding changes such that the Department can not complete the Contract.

3.8 TURNOVER

3.8.1 Contractor acknowledges the need for continuity in claims processing and that there can be no disruption of services during a turnover from the Contractor to the MCO or to a successor contractor, if any, at the expiration or termination of this Contract. Accordingly, the Contractor will cooperate fully in providing for an orderly and controlled transition and will minimize any disruption in the services to be performed under this Contract.

3.8.2 Notwithstanding any other provision in this Contract, the Contractor shall continue providing Contract services until the Department and MCO determine that the MCO or a successor contractor is prepared to fully assume the Contractor's duties and obligations under this Contract and the Participating Agreement. All the terms and conditions of the Contract will apply during this period.

3.8.3 To assure no disruption in the event of a termination, the Contractor will notify the Department immediately upon a reasonable threat to its insolvency or a consideration of dissolution as a legal entity. The Contractor and the Department will develop a plan to monitor the Contractor's ability to continue to provide services and transition into a possible termination of services. That plan must include how the Contractor will assure that claims processing continues until the MCO or a successor contractor is prepared to fully assume the Contractor's duties.

3.9 CONTRACTOR TO ACT AS PRIME CONTRACTOR. Each Contractor shall act as a prime contractor under the Contract, and shall be the sole point of contact with the Department in regard to all contractual matters, including the performance of services, reporting, issuance of invoices, and the payment of any and all charges resulting from contractual obligations involving Contractor personnel or subcontractors.

The Contractor may enter into subcontracts with third parties, including subcontractors, and service providers, for the performance of any part of Contractor's duties and obligations, provided, that in no event shall the existence of the subcontract operate to release or reduce the liability of Contractor to the Department for any obligations under the Contract or breach in the performance of Contractor's duties.

All subcontractors shall be agents of the Contractor for the purposes of the Contract and the Contractor shall hold the Department harmless hereunder for any loss or damage of any kind occasioned by the acts or omissions of the Contractor's subcontractors, their agents or employees. Copies of Contractor's subcontracts with third parties may be requested by the State.

3.10 COOPERATION WITH OTHER CONTRACTORS. In the event that the Department enters into a contract with another contractor for additional services related to this Contract, the Contractor shall ensure that its personnel fully cooperate with such other contractor. Contractor personnel shall not commit any act that shall interfere with the performance of services by any other Contractor or by the State. Contractor personnel shall cooperate with Department personnel and other Contractors to complete the engagement work.

3.11 TRAINING. Training costs for the Contractor are not covered under this Contract. All necessary training for the Contractor's personnel shall be the responsibility of the Contractor.

3.12 NONDISCRIMINATION AND AFFIRMATIVE ACTION. The Contractor shall provide the Department's Office of Affirmative Action and Civil Rights Compliance a complete Affirmative Action, Equal Opportunity, Civil Rights Compliance and Limited English Proficiency Plan within 15 calendar days from the date the contract is signed. The contractor shall comply with all of the requirements set forth in the Department's Affirmative Action, Equal Opportunity, Civil Rights Compliance and Limited English Proficiency requirements. The Affirmative Action and Civil Rights Compliance Plan Instructions and Manual for Private and Non-Profit Entities revised on November 17, 2003 can be found in the following Department's web site:
<http://dhs.wisconsin.gov/civilrights/Index.HTM>

Contractors and their subcontractors are encouraged to contact the Department of Health Services Affirmative Action and Civil Right's Compliance Office at (608) 266-9372 for technical assistance.

The Civil Rights Compliance Plan contains three components: Affirmative Action, Equal Opportunity/Civil Rights, and Language Access.

3.12.1 Affirmative Action. The Contractor shall complete the Affirmative Action, Equal Opportunity, Civil Rights Compliance and Language Access sections of the Plan that may cover a two or three-year period, unless it is exempt under the following criteria. If exempt, the Contractor must still submit proof of exemption.

Exemption from Submitting Affirmative Action Component:

1. The organization has less than twenty-five (25) employees regardless of the dollar amount of the contract;
2. The organization is a foreign company with a work force of less than twenty-five (25) employees in the U.S.;
3. The organization is a federal government agency or a Wisconsin municipality;
4. The organization has a balanced workforce.

If exempt from submitting an Affirmative Action component, the Contractor must submit evidence of exemption as follows:

- If exempt from submitting an Affirmative Action component based on criteria 2 through 4 above, the Contractor still must submit a Request for Exemption from Submitting an Affirmative Action Component and the Contractor's Subcontractor List;
- If exempt from submitting an Affirmative Action component because it has a balanced work force (criteria 4), the Contractor still must submit the Bidder's Work Force Analysis Form, a Request for Exemption from Submitting Affirmative Action Component and the Contractor's Subcontractor List.

Affirmative Action component is written in detail and explains the Contractor's affirmative action program. The Affirmative Action component must be prepared in accordance to the most recently revised Affirmative Action, Equal Opportunity, Civil Rights Compliance and Language Access Plan Instruction and Manual.

In addition, the Contractor shall conduct, keep on file, and update annually, a separate and additional accessibility self-evaluation of all programs and facilities, including employment practices for compliance with the American with Disabilities (ADA) Title I regulations, unless an updated self-evaluation under Section 503 of the Rehabilitation Act of 1973 exists that meets the ADA requirements. For technical assistance on all the aspects of Civil Rights Compliance, to the Contractor may contact the Department's Affirmative Action/Civil Rights Compliance Office at (608)-266-9372 (voice), (608)-266-2555 (TTY), or at the Department of Health Services, 1 W. Wilson Street, Room 555. P.O. Box 7850, Madison, Wisconsin 53707-8750.

3.12.2 Civil Rights Compliance. The Contractor must submit to the Department's Affirmative Action and Civil Rights Compliance Officer proof that it complies with all of the requirements in the Affirmative Action, Equal Opportunity, Civil Rights Compliance and Language Access Plan Instructions and Manual for Profit and Non-Profit entities. For Affirmative Action, Equal Opportunity, Civil Rights Compliance and Language Access Plans approved during the previous year that have not expired, the Contractor must submit proof that the Plan or a section of the Plan is approved for the current contract year or must submit a plan update for the contract period.

For nondiscrimination in service delivery and in employment, the Contractor must comply with civil rights requirements, including all applicable Federal and State laws relating to non-discrimination and equal employment opportunity. These include: the Federal Civil Rights Act of 1964, and regulations pursuant to that Act and the provisions of Federal Executive Order 11246 dated September 26, 1985; sections 503 and 504 of the Federal Rehabilitation Act of 1973, as amended (29 U.S.C. 794), and all requirements imposed by the applicable Department regulations (45 CFR part 84) and all guidelines and interpretations issued pursuant thereto; the provisions of the Age Discrimination and Employment Act of 1967 and the Age Discrimination Act of 1975; Title VI and XVI of the Public Health Act; the Omnibus Reconciliation Act of 1981; the Americans with Disabilities Act of 1990; section 16.765, Wis. Stats., and ADM 50 of the Wisconsin Administrative Code and the Wisconsin Fair Employment Act.

Requirements:

- a. No otherwise qualified person shall be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination in any manner on the basis of race, color, national origin, sexual orientation, religion, sex, disability or age. This policy covers eligibility for and access to service delivery, and treatment in all programs and activities. All employees of the Contractor are expected to support goals and programmatic activities relating to nondiscrimination in service delivery.
- b. Sec. 16.765, Wis. Stats., and ADM 50 require that in connection with the performance of work under this contract, the Contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical conditions, development disability as defined in s. 51.01 (5), sexual orientation or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotions or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the Contractor further agrees to take affirmative action to ensure equal employment opportunity. The Contractor agrees to post in conspicuous place, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provision of the non-discrimination clause.
- c. No otherwise qualified person shall be excluded from employment, be denied the benefit of employment or otherwise be subject to discrimination in employment in any manner or term of employment on the basis of disability (as defined in Section 504 of the Rehabilitation Act and the ADA), arrest or conviction record, marital status, political affiliation, military participation, the use of legal products during non-working hours, non-job related genetic and honesty testing. All employees are expected to support goals and programmatic activities relating to non-discrimination in employment.
- d. The Contractor must post the Equal Opportunity Policy, the name of the Equal Opportunity Coordinator and the discrimination complaint process in conspicuous places available to applicants and clients of services, and applicants for employment and employees. The complaint process will be according to Department requirements and made available in languages and formats understandable to enrollees, applicants and employees. The Department will continue to provide appropriate translated program brochures and forms for distribution.
- e. The Contractor agrees to comply with all of the current requirements in the Affirmative Action, Equal Opportunity, Civil Rights Compliance and Language Access Plan for Profit and Non-Profit Entities and their subcontractors.

3.12.3 Subcontracts. These requirements apply to any subcontracts or sub-grantees. The Contractor has primary responsibility for ensuring that its subcontractors or sub-grantees also comply with all of the requirements of the Department's Affirmative Action, Equal Opportunity, Civil Rights Compliance and Language Access Plan for Profit and Non-Profit Entities. The Contractor further agrees to:

1. Provide the Department's Office of Affirmative Action and Civil Rights Compliance with the Contractor's "Vendor Subcontract List" within 15 calendar days of the award date of the contract to identify any subcontractor

- or specify that none exist. If the Contractor changes its subcontracts or decides to subcontract at a later date, the Contractor must revise and submit its subcontractor list at the time of altering its subcontracting;
2. The Contractor is required to notify any subcontractor to comply with the Department's Affirmative Action requirements in the same manner as the Contractor;
 3. Require in each subcontract that the provisions for nondiscrimination and affirmative action in employment practices apply to the subcontractor on the same basis as they apply to the Contractor; and
 4. Give a copy of Wisconsin's Contract Compliance Law to each subcontractor to post in a conspicuous place. Copies are available from the Department Office of Affirmative Action and Civil Rights Compliance.

For a Subcontract over \$25,000, the Contractor must obtain one of the following and forward it to the Office of Affirmative Action and Civil Rights Compliance:

- An exemption statement from the subcontractor if it has less than twenty-five (25) employees or for other reasons noted on the "Request for Exemption from Submitting Affirmative Action Plan"; or
- An Affirmative Action Plan from the subcontractor; or
- A copy of its Office of Federal Contract Compliance letter dated within the last year and its Affirmative Action policy statement.

3.12.4 Monitoring. The Department will monitor the Affirmative Action Equal Opportunity, Civil Rights and Language Access compliance of the Contractor. The Department will conduct reviews to ensure that the Proposer is ensuring compliance by its subcontractors according to the guidelines in the Affirmative Action, Equal Opportunity, Civil Rights and Language Access Compliance Plan. The Contractor agrees to comply with the Civil Rights monitoring reviews, including the examination of records and relevant files maintained by the Contractor, as well as interviews with staff, clients, and applicants for services, subcontractors, sub-grantees, and referral agencies. The review will be conducted according to Department procedures. The Department will also conduct reviews to address immediate concerns of complainants.

The Contractor agrees to cooperate with the Department in developing, implementing and monitoring corrective action plans that result from complaint investigations or monitoring efforts.

3.13 SEVERABILITY. If any provision of the Contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both the State of Wisconsin and the Contractor shall be relieved of all obligations arising under such provision. If the remainder of the Contract is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed.

3.14 EXAMINATION OF RECORDS. The Department shall, at any time during Contractor's regular business hours and upon at least twenty-four (24) hours advance written notice, have access to and the right to examine, audit, excerpt, transcribe, and copy, on Contractor's premises, any directly pertinent records and computer data storage media of Contractor involving transactions relating to this Contract. All Department representatives on Contractor's premises shall comply with Contractor's security requirements. If the material is on computer data storage media, Contractor

shall provide copies of the data storage media or such computer printout as may be requested by the State. Contractor, following final payment, shall retain such material for three (3) years. This provision shall also apply in the event of termination pursuant to Section 3.7, Termination, of this Contract. Any charges for copies provided by Contractor of books, documents, papers, records, computer data storage media or computer printouts shall not exceed the actual cost to Contractor.

3.15 INDEMNIFICATION. The Contractor shall indemnify, defend, and hold harmless the State from and against any losses, liability, claims, damages, penalties, costs, fees or expenses, including, without limitation, penalties and damage resulting from personal injury or damage to property, caused by or arising from its performance of its duties and obligations under this Contract, or the acts or omissions of its officers, employees, agents or subcontractors. The State agrees to be responsible to the Contractor for any liability, losses, claims, damages, costs, fees or expenses, including, without limitation, personal injury or damage to property which are caused by or arises out of any negligent or intentional act or omission of the Department or any of its officers, employees, agents or subcontractors while acting within the scope of their employment, where protection is afforded by sections 893.82 and 895.46(1), Wis. Stats.

3.16 FINANCIAL STATEMENTS. Upon request, Contractor shall supply the Department with a copy of its year-end audited financial statement, and the annual update of the SAS 70 report, not later than one hundred and twenty (120) calendar days after its fiscal year-end.

3.17 LIABILITY FOR LOSS OF DATA. When computer services are used to complete the work for the engagement, the Department shall maintain adequate supporting material or copies to enable Contractor to regenerate card files, tape files, printer outputs and other data furnished to Contractor by the State. In the event of loss of such Department supplied data due to machine failure or negligence of Contractor or its personnel, Contractor shall be liable for such loss and shall replace or regenerate the lost data from the State's supporting material by the methods or means deemed most suitable as agreed between the parties.

3.18 PROPRIETARY INFORMATION / INTELLECTUAL PROPERTY. The Department acknowledges that Contractor's forms, methods, systems, procedures, data format, data gathering and retrieval system and methods, and all Contractor computer software, computer hardware, program names, design and manuals, are confidential and proprietary information owned by and proprietary to Contractor and are subject to the same protection as Confidential Information under Section 3.6 of this Contract.

Contractor retains all intellectual property rights, including all patent, copyright, service mark, trade name and trademark rights, in the written materials, products, software, and services it provides under this Contract, as well as in all other materials provided to the Department which are not expressly waived, in writing, under the laws and regulations of the United States, any state of the United States, or of any foreign country. No license, expressed or implied, is granted by Contractor to the Department under this Contract.

3.19 SURVIVAL. The terms, conditions and warranties contained in the Contract that by their sense and context are intended to survive the performance under this Contract shall so survive the completion, cancellation or termination of the Contract. Specifically, but without limitation, the terms regarding insurance, confidentiality and hold

harmless/indemnification shall survive.

APPENDIX A - CLARIFICATION OF REQUIREMENTS

Req. Number	Requirement text / clarification
4.1.2	Provide systems support to the contracting organization during extended work hours (e.g., 6:00 a.m. to 6:00 p.m., Monday through Friday).
Clarification:	Provide systems support to the contracting organization from 6:00 a.m. to 5:00 p.m. and on-call support from 5:00 p.m. to 6:00 p.m., Monday through Friday).
4.1.3	Maintain electronic images of all claims-related service documents and provide for remote retrieval of these images including, but not limited to: <ul style="list-style-type: none"> - Claims. - Service authorizations. - Receivables. - New recipient set up. - Provider additions and changes.
Clarification:	Changed from Organization Level Contracting to Bulletin Level Setup.
4.1.5	Ensure electronic data transfers comply with HIPAA transaction format requirements, as applicable.
Clarification:	Ensure electronic data transfers comply with HIPAA transaction format requirements for Health Care Claims (837), Remittance Advice (835), Enrollment (834), Functional Acknowledgement (997), Status Request and Response (276, 277), and Referral Certification and Authorization (278).
4.1.6	Ensure all functions operate in accordance with the HIPAA final and amended rules for security and privacy.
Clarification:	Intent of the requirements is to prevent breach or inappropriate access, and to support confidentiality. Vendors must comply with an approved security protocol.
4.1.8	Provide a flexible solution to effectively meet the requirements of upcoming HIPAA regulations and other national standards development. The system must accommodate changes with global impacts (e.g., implementation of ICD-10-CM diagnosis and procedure codes, eHR, e-Prescribe) as well as new transactions (e.g., ASC X12N 275: Additional Information to Support a Healthcare Claim) at no additional cost.
Clarification:	Additionally, vendors must prohibit custom claims code usage. All codes must comply with standardized, department approved codes. The system must not allow non-vendor personnel the ability to create or modify codes. All modifications will be established and approved by the DHS Code

Committee.

- 4.1.10 Accept and process or generate the following HIPAA mandated batch and real-time transactions, other versions or standards that may be mandated and other transactions including, but not limited to:
- Health care claims (professional, institutional).
 - Eligibility for a health plan.
 - Health care services review - request for review and response.
 - Health care claim status request and response.
 - Benefit enrollment and maintenance.
 - Health care claim payment/advice.
 - Payroll deducted and other group premium payment for insurance products.
 - Coordination of benefits for health care claims (professional, institutional).
 - Functional acknowledgements.

Clarification: Vendors must have the capacity to process these HIPAA transaction formats before they can begin contracting with MCOs: Health Care Claims (837), Remittance Advice (835), Enrollment (834), Functional Acknowledgement (997), Status Request and Response (276, 277), and Referral Certification and Authorization (278).

- 4.1.11 Comply with all HIPAA transaction implementation guides.

Clarification: Vendors must comply with HIPAA implementation guide for these transaction formats before they can begin contracting with MCOs: Health Care Claims (837), Remittance Advice (835), Enrollment (834), Functional Acknowledgement (997), Status Request and Response (276, 277), and Referral Certification and Authorization (278).

- 4.1.14 Establish and manage a user group for contracting organizations.

Clarification: User group meetings are to be held at least twice a year with one of the meetings being a face-to-face.

- 4.1.15 Participate in the DHS code committee and comply with decisions made by the committee; describe the qualifications of staff available for participation.

Clarification: Formal names are not required in the response, and participation is not limited to the staff person named in the response. Each vendor participant will be a person with decision-making authority and appropriate knowledge and experience.

- 4.1.16 Participate in the DHS IT Workgroup, QA/QI workgroups, and any other DHS workgroups as requested by either the DHS or the contracting organization; describe the qualifications of staff available for participation in the IT and QA/QI workgroups.

Clarification: Participate in the DHS IT Workgroup, and Code Committee. Other workgroup participation may be requested by the MCO and can be clarified in the Participating Agreements.

4.2.3 Allow the submittal of decimal units and calculate payment based on the decimal versus rounding to a whole unit, as required by contracting organizations, and as directed by DHS policy.

Clarification: The MCO Participating Agreements must accommodate provider transition from partial to whole unit submission for those MCOs that are currently using partial units.

4.2.4 Link subsequent submitted claims to denied claims when possible.

Clarification: Link subsequent submitted claims to denied claims when identified as an adjustment. This item is not required, but may be provided at the contractor's discretion.

Additionally, systems must automatically identify potential duplicates for resolution.

4.2.5 Periodically assess the fiscal impact of accepting Medicare crossover claims with the DHS and the contracting organization to agree upon the cost benefit of implementing the service or discontinuing the service. (Include frequency of assessments in your response.)

Clarification: Provide annual report of volume of potential crossover claims to cost and provide recommendations regarding the implementation of the service.

4.2.6 Implement restrictions on conditions to be met for a claim to be paid within the benefit packages including, but not limited to:

- Provider type.
- Provider specialty.
- Category of service (SPC).
- Recipient age.
- Recipient sex.
- Place of service.
- Procedure codes
- Modifiers.
- Diagnosis codes.

Clarification: Implement restrictions on conditions to be met for a claim to be paid within the benefit packages including:

- Provider type.
- Provider specialty.
- Category of service (SPC).
- Recipient age.
- Recipient sex.
- Place of service.
- Procedure codes.
- Modifiers.

- Diagnosis codes.

Specific details of restrictions are to be addressed by the MCO Participating Agreements.

- 4.2.7 Implement DHS or contract specified restrictions on conditions to be met for a claim to be paid within the benefit packages (which include multiple waiver programs), including the ability to vary claim resolution actions (e.g., pay, pend, deny) by line of business and by error type.

Clarification: This requirement is intended to ensure the PMPM reflects the vendor's ability to provide the service therefore, the PMPM costs must cover the flexibility to set up separate lines of business for each contracting organization.

- 4.2.8 Place edit and/or audit criteria limits on types of service by procedure code, by revenue code, by diagnosis code, by drug class, or based on specified data elements (e.g., recipient information, provider type and specialty, time periods, units, cost).

Clarification: This requirement is intended to ensure the PMPM reflects the vendor's ability to provide the service therefore, the PMPM costs must cover the flexibility to set up separate lines of business for each contracting organization.

- 4.2.9 Implement restrictions on conditions to be met for a claim to be paid within the benefit packages based on contracting organization agreements including, but not limited to:

- Accident-related and insurance-related indicators for coordination of benefits.
- Required attachment indicators.
- Prior authorization indicators and effective date(s).
- DME limitations (i.e., life expectancy).
- Medicare Part A-covered service and effective date(s).
- Medicare Part B-covered service and effective date(s).
- Co-pay indicator and effective date(s).

Clarification: This requirement is intended to ensure the PMPM reflects the vendor's ability to provide the service therefore, the PMPM costs must cover the flexibility to set up separate lines of business for each contracting organization.

- 4.2.13 Maintain reference data that supports claims edits, audits, and pricing logic in accordance with DHS and contracting organization policies. The application of these policies is subject to change; therefore, the edits, audits, and pricing methodologies described in this RFP shall not be considered an exhaustive list.

Clarification: Maintain data required to support claims adjudication. Ensure the MCO has access to the data required for operations. The application of these policies is subject to change; therefore, the edits, audits, and pricing

methodologies described in this RFP shall not be considered an exhaustive list.

- 4.2.14 Maintain and update HIPAA mandated code sets, approved versions of HCPCS procedure codes, ICD-9-CM diagnosis and procedure codes, CDT procedure codes, revenue codes, Diagnostic Related Groups (DRG), and NDC drug codes.

Clarification: Updates must be scheduled prior to effective dates of respective codes with the exception of retroactive changes.

- 4.2.15 Obtain regularly scheduled updates for HCPCS and CPT from CMS and AMA.

Clarification: Updates must be scheduled prior to effective dates of respective codes with the exception of retroactive changes.

- 4.2.18 The procedure code file must contain parameters used in claims processing including, but not limited to, provider type, specialty, recipient age and gender restrictions, place of service, modifier, claim type, diagnosis, units of service, and dates of service.

Clarification: The procedure code file must contain parameters used in claims processing including provider type, specialty, recipient age and gender restrictions, place of service, modifier, claim type, diagnosis, units of service, and dates of service.

- 4.2.20 Maintain revenue code files with a data set that contains, but is not limited to:
- Maximum revenue code history with a minimum of seven (7) years after the end date of status code segments with effective begin and end dates for each segment.
 - Numerous parameters used in claims processing including but not limited to: provider type, specialty, sub-specialty, recipient age and/or gender restrictions, claim type, diagnosis, units of service, and review indicator.
 - Information such as accident-related indicators for possible TPL, federal cost-sharing indicators, Medicare coverage, and allowed amounts.

Clarification: Maintain historical service code data with sufficient elements to reconstruct claims process.

- 4.2.21 Maintain a drug file using the NDC, which can accommodate regular, periodic updates from a contracted drug pricing service, as specified by contracting organizations.

Clarification: Updates must be scheduled prior to effective dates of respective codes with the exception of retroactive changes.

- 4.2.26 Maintain positive and negative data relationships. The types of relationships shall include, but are not limited to, procedure to provider

types and specialties, procedure-to-procedure, procedure to diagnosis, procedure to recipient age, and procedure to recipient gender.

Clarification: Maintain positive and negative data relationships. The types of relationships shall include: procedure to provider types and specialties, procedure-to-procedure, procedure to diagnosis, procedure to recipient age, and procedure to recipient gender.

4.2.29 Process third party coverage updates received from certifying agencies, providers, and as a result of errors in processing insurance company file matches. (Include frequency of updates in your response.)

Clarification: Accept other insurance information and updates for members from a variety of sources, including certifying agencies and providers to be used in claims adjudication.

4.2.30 Maintain all third party resource information at the recipient-specific level including, but not limited to:

- Carrier name and identifier.
- Policy number and group number.
- Effective date of coverage and end date of coverage, if applicable.
- Add date, change date and verification date of insurance.
- Source of the insurance information identifier.
- Type of verification of insurance identifier.
- Policy holder name, address, SSN, date of birth, relationship to insured, employer name and address.
- Specific information on types of services covered by the policy, as defined by the contracting organization.
- Part A and/or Part B Medicare.
- Medicare Managed Care plan.
- Medicare Supplemental plan.
- Drug Plan.
- Tricare.

Clarification: Maintain all third party resource information at the recipient-specific level with sufficient information to accurately process claims and coordinate benefits.

4.2.31 Maintain a file of all carriers during the life of the contract that includes, but is not limited to:

- Carrier name and identifier.
- Technical contact name and phone number.
- Corporate contact name, address and telephone number.
- Claims submission address and phone number.
- Indicators of coverage by defined categories of services as applicable.
- Active or inactive status.

Clarification: Maintain a file of all carriers during the life of the contract that appropriately identifies other insurance demographics, and is sufficient to successfully make inquiries of other insurance providers.

4.2.32 Maintain all third party resource information at the recipient-specific level including, but not limited to, names, identifiers, unlimited number of other insurance plans, policy and group numbers, coverage dates, sources, services, and payers. Provide third party coverage investigation services, based on injury-related diagnoses, and conduct regular queries to proactively update recipients' other insurance information.

Clarification: The requirement to “conduct regular queries to proactively update recipients' other insurance information” is an option at the MCO level and needs to be specified in the MCO Participating Agreement. The remainder of this requirement applies to the Department master contract.

4.2.35 Coordinate benefits with other insurance benefits including, but not limited to:

- Subrogation.
- Worker's Compensation.
- Medicare.
- Medicaid.
- Private health, long-term care, casualty, or liability.

Clarification: Coordinate benefits with other insurance benefits including:

- Subrogation.
- Worker's Compensation.
- Medicare.
- Medicaid.
- Private health, long-term care, casualty, or liability.

4.2.37 For each edit and/or audit exception, provide all resolution information including, but not limited to, a resolution code; an override, force or deny indicator; and the date the error was resolved, forced, or denied, and by whom. All claims must carry sufficient information to provide a complete online audit trail of all exception processing. These data elements shall be maintained in the claims history to support provider and claims processing audits.

Clarification: For each edit and/or audit exception, provide all resolution information including: a resolution code; an override, force or deny indicator; and the date the error was resolved, forced, or denied, and by whom. All claims must carry sufficient information to provide a complete online audit trail of all exception processing. These data elements shall be maintained in the claims history to support provider and claims processing audits.

4.2.39 Support and maintain a cross reference file that connects standard codes, rates, and COB information used by the long term care, waiver, and other DHS programs for pre-authorizations, claims processing, encounter reporting, research, and analysis, and benefit packages.

Clarification: Support and maintain reference information to ensure the data used for any part of the claims adjudication process is the same data used in all other parts of the process.

4.2.40 Receive claims in a variety of mediums including, but not limited to, HIPAA-compliant electronic formats and paper documents from providers, billing services, contracting organizations, Medicare carriers and intermediaries, and coordination of benefits contractors.

Clarification: Receive claims in a variety of mediums including: HIPAA-compliant electronic formats and paper documents from providers, billing services, contracting organizations, Medicare carriers and intermediaries, and coordination of benefits contractors.

4.2.43 Accept paper and HIPAA-compliant electronic attachments and link to the original claim using the ICN. Attachments should carry the ICN of the claim record with a suffix or other indicator identifying it as an attachment.

Clarification: This applies to HIPAA 5010 implementation.

4.2.46 Accept additional claim inputs, including but not limited to:

- Claims for Medicare coinsurance and deductible (crossover claims), in both paper and electronic formats.
- Attachments required for claims adjudication, including coordination of benefits and Medicare explanation of medical benefits.
- Non-claim specific financial transactions such as fraud and abuse settlements, insurance recoveries, and cash receipts.
- Subrogation.
- Worker's Compensation.
- Reinsurance payments.

Clarification: Accept additional claim inputs, including:

- Claims for Medicare coinsurance and deductible (crossover claims), in both paper and electronic formats.
- Attachments required for claims adjudication, including coordination of benefits and Medicare explanation of medical benefits.
- Non-claim specific financial transactions such as fraud and abuse settlements, insurance recoveries, and cash receipts.
- Subrogation.
- Worker's Compensation.

4.2.47 Establish controls to ensure that no paper claims and attachments, tapes, discs, or other data are misplaced, lost, or duplicated after receipt.

Clarification: Establish controls to ensure that paper claims and attachments, tapes, discs, or other data are controlled from receipt to application in the system so that no information is misplaced, lost, or duplicated after receipt.

4.2.48 Edit all required data elements for presence and validity on all entered claims, according to DHS specifications, as directed by the contracting organization.

Clarification: This requirement is intended to ensure the PMPM reflects the vendor's ability to provide the service therefore, the PMPM costs must cover the flexibility to set up separate lines of business for each contracting

organization.

- 4.2.52 Maintain information on benefit package coverage including, but not limited to, recipients; providers; programs; place of service; procedure, modifier, and diagnosis codes; services authorized under each benefit package; and services included or excluded for each benefit package.

Clarification: Maintain information on benefit package coverage including: recipients; providers; programs; place of service; procedure, modifier, and diagnosis codes; services authorized under each benefit package; and services included or excluded for each benefit package.

- 4.2.54 Support the administration of a variety of benefit packages and claims processing and program administration requirements.

Clarification: This includes CMS requirements for administration of long-term care managed care waiver programs and children's waiver programs.

- 4.2.59 Systematically accept global changes to suspended claims, based on defined criteria, and release claims for editing.

Clarification: Vendors must have the capability to accept global changes to suspended claims, based on defined criteria, and release claims for editing. Criteria will be established by each MCO.

- 4.2.61 Edit for recipient eligibility and enrollment on date(s) of service.

Clarification: Edit for recipient enrollment on date(s) of service.

- 4.2.62 Edit for valid billing, attending, rendering, referring, and/or prescribing provider number or NPI, as appropriate.

Clarification: Edit for valid billing and rendering provider number (NPI or agree-upon atypical enumeration format), and prescribing provider number or NPI as appropriate for pharmacy claims.

- 4.2.63 Edit for prior authorization requirements, and verify the claim services match an active prior authorization for those services, independent of the pre-authorization identification number.

Clarification: Vendors must be able to apply edit criteria and verify claim services against prior authorizations that do not have identification numbers. The intent of this requirement is to prevent denial of claims which are submitted without a pre-authorization identification number, but which contain enough information to match the authorization and process the claim. This is a core requirement and is specified at the bulletin level; therefore, the vendor will not be able to require the presence of authorization IDs on claims through MCO agreements.

- 4.2.64 Edit to assure the claim is from an authorized provider. Generate notifications when a non-authorized provider is submitting a claim.

Clarification: Edit to assure the claim is from an authorized provider. Generate appropriate message on EOB or remittance advice when a non-authorized provider is submitting a claim.

4.2.69 Perform automated audit processing using history claims, suspended claims, in-process claims, and same cycle claims.

Clarification: Perform automated edit processing using history claims, suspended claims, in-process claims, and same cycle claims.

4.2.78 Return claims to providers that do not meet approved screening criteria.

Clarification: Return claims that lack sufficient data to identify member, service, or critical elements required to process the claim.

4.2.83 Assure that Medicare crossover claim and adjustment media types are uniquely identified on all standard claim statistic reports.

Clarification: Assure that Medicare claim and adjustment media types are uniquely identified on all standard claim statistic reports.

4.2.87 Process individual, mass, and gross adjustments submitted as HIPAA-compliant electronic transactions and as paper transactions.

Clarification: Process individual, mass, and gross adjustments.

4.2.93 Update provider payment history and recipient claims history with all appropriate financial records and reflect adjustments in subsequent reporting, including claim specific and non-claim specific recoveries. Refund non-claim specific financial payments and recoveries, as defined by individual agreement.

Clarification: Non-claim specific receivables are to be returned to the MCO account.

4.2.96 Maintain all claim history (original claims and all previous adjustments) with all of the original information including, but not limited to, the original paid amount, the adjusted amount, the full amount gross calculated, and the net amount calculated.

Clarification: Maintain all claim history (original claims and all previous adjustments) with all of the original information including: the original paid amount, the adjusted amount, the full amount gross calculated, and the net amount calculated.

- 4.2.99 Identify and calculate payment amounts according to established rules and rates. Accommodate these and any future pricing methods:
- Rate on file or billed amount, whichever is less.
 - Percentage of rate on file.
 - Anesthesia Pricing using a formula.
 - DRG pricing.
 - Procedure code modifier pricing.
 - Manual pricing.
 - Nursing home daily rate.
 - Nursing home prospective payment system.
 - Resource Utilization Groups (RUGs)
 - Long Term Acute Care Hospital (LTACH)
 - Facility specific per diem rate.
 - Outpatient hospital rate per visit (day).
 - Outpatient prospective payment system.
 - Crossover claim pricing, including Part B pricing reductions.
 - Incentive payment pricing.
 - MAC, EAC, or AWP minus a percentage for drugs plus dispensing fee per prescription. These are prescription pricing methodologies.
 - Individual waiver program pricing methodologies.

Clarification: Identify and calculate payment amounts according to established rules and rates. Accommodate these pricing methods:

- Rate on file or billed amount, whichever is less.
- Percentage of rate on file.
- Anesthesia Pricing using a formula.
- Manual pricing.
- DRG pricing.
- Procedure code modifier pricing.
- NH daily rate.
- Facility specific per diem rate.
- Outpatient hospital rate per visit (day).
- Crossover claim pricing, including Part B pricing reductions.
- Medicare and Medicaid required Fee For Service methodologies.

Nursing home prospective payment system, Resource Utilization Groups (RUGs), and Long Term Acute Care Hospital (LTACH) pricing may be required, based on CMS requirements.

- 4.2.100 As needed, apply all of the above mechanisms according to:
- Geographic area by county or ZIP code of provider or recipient.
 - Individual provider number.
 - Provider number.
 - Individual recipient identification number.
 - Recipient age, gender, or aid category.
 - Provider type or specialty.

Clarification: As needed, apply all of the above mechanisms (in 4.2.99) according to:

- Geographic area by county or ZIP code of provider or recipient.
- Individual provider number.

- Level of care.
- Individual recipient identification number.
- Recipient age, gender, or aid category.
- Provider type or specialty.

4.2.109 Generate a simplified provider remittance advice for atypical providers that reflects data specific to atypical services.

Clarification: Generate a provider remittance advice for atypical providers that reflects data specific to atypical services.

4.2.110 Provide the ability to collect the contracting organization's internally provided case management services data (e.g., case management) for reporting purposes but suppress payments for these services.

Clarification: This requirement applies to service records, not case management records. Audits must balance services against claims history. Claims service history is expected to balance against financial records.

4.2.111 Meet all paper claims and adjustment processing standards set by the state or the federal government. These standards include processing claims as follows:

- Ninety percent (90%) of all claims shall be processed within ten (10) calendar days of receipt.
- Ninety-five percent (95%) of all claims shall be processed within twenty-one (21) calendar days of receipt.
- Ninety-nine percent (99%) of all claims shall be processed within thirty (30) calendar days of receipt.
- One hundred percent (100%) of all claims shall be processed within ninety (90) calendar days of receipt.

Clarification: This is no longer a bulletin level requirement. The contractual agreement between the MCO and the vendor must accommodate the Department/MCO contract in effect at the time the MCO TPA contract is established. Specific language, percentages, and time frames for this requirement will be negotiated at the MCO level.

4.2.113 Meet all electronic claims and adjustment processing standards set by the state or the federal government. These standards include processing claims as follows:

- Ninety percent (90%) of all claims shall be processed within five (5) calendar days of receipt.
- Ninety-five percent (95%) of all claims shall be processed within ten (10) calendar days of receipt.
- Ninety-nine percent (99%) of all claims shall be processed within fifteen (15) calendar days of receipt.
- One hundred percent (100%) of all claims shall be processed within twenty (20) calendar days of receipt.

Clarification: The MCO Participating Agreement must meet the requirements of the contract between the MCO and the Department.

4.2.114 Accept contracted rate information from the contracting organization. Price provider claims using provider specific and program specific contracted rates for recipients. Also, price based on individual pre-authorization negotiated rates, as required by the contracting organization, or based on Medicaid rates.

Clarification: This requirement is intended to ensure the PMPM reflects the vendor's ability to provide the service therefore, the PMPM costs must cover the flexibility to set up separate lines of business for each contracting organization.

4.2.119 Generate expenditure, eligibility and utilization data to support budget forecasts, monitoring and health care program modeling.

Clarification: Generate expenditure, enrollment and utilization data to support budget forecasts, monitoring and health care program modeling.

4.2.130 Accommodate atypical coordination of benefit requirements based on contracting organization or program agreements (e.g., pay and pursue for other insurance, subrogation or workers' compensation).

Clarification: The vendor is expected to pay and pursue for all injuries unless suspected for workers compensation (pursue and pay). The MCO will specify individual circumstances for atypical service handling.

4.2.131 Interface with Medicare contractors to exchange eligibility information, and other data as specified by the DHS or the contracting organization, to use in matching information for Medicare crossover claims, if applicable.

Clarification: Interface with Medicare contractors to exchange eligibility information and to receive Medicare crossover claims, if applicable.

4.3.4 Provide an automated fraud and abuse profiling system for the ongoing monitoring of provider and recipient claims to detect patterns of potential fraud, abuse, and excessive billing. The system must be able to perform targeted or intensive monitoring of specific providers, services, procedures, diagnoses, and/or recipients over time. Monitoring includes, but is not limited to:

- Bundling and unbundling.
- Medically unnecessary services.
- Overuse of services for all claims, provider types, and recipient categories.
- Medically unnecessary care.
- Fraud and abuse by providers.
- Fraud and abuse by recipients.
- Fraud and abuse by TPA, contracting organization, and any other contracted employees.
- Inappropriate billing practices.
- Clinically inappropriate or unnecessary utilization compared to nationally recognized practice parameters.

Clarification: Provide an automated fraud and abuse profiling system for the ongoing monitoring of provider and recipient claims to detect patterns of potential fraud, abuse, and excessive billing. The system must be able to perform targeted or intensive monitoring of specific providers, services, procedures, diagnoses, and/or recipients over time. Monitoring includes:

- Bundling and unbundling.
- Overuse of services for all claims, provider types, and recipient categories.
- Fraud and abuse by providers.
- Fraud and abuse by recipients.
- Fraud and abuse by TPA personnel, contracting organization, and any other contracted employees.
- Inappropriate billing practices.
- Clinically inappropriate or unnecessary utilization compared to nationally recognized practice parameters.

4.4.24 Pend accounts receivable collections for bankruptcies and deaths. Generate reports for Medicaid estate recovery as defined by the DHS.

Clarification: Estate recovery report needs include access to history, access to (or reports of) claims and receivables by individual, and pre-authorizations for nursing homes (weekly report or access).

4.4.25 Collect appropriate accounts receivables based on bankruptcy court resolution.

Clarification: Collect appropriate claims accounts receivables based on bankruptcy court resolution.

4.4.26 Establish and maintain a recoupment process that includes supporting documentation for instances of overpayments, incorrect payments or payments to ineligible payers.

Clarification: Vendors must have the capability to process recoupments. MCOs have the flexibility to determine offset policies.

4.4.27 Maintain multiple receivable accounts by payer.

Clarification: Maintain multiple claims receivable accounts by payer. This includes both claims and member share receivables, if applicable.

4.4.31 Accept and process HIPAA-compliant electronic remittance advice from payers for posting payments received.

Clarification: This requirement applies to Medicare crossover claims. It has been changed from PMPM to an optional requirement.

4.4.33 Perform accounts receivable functions to include, but not limited to:

- Collection of overpayments.
- Maintenance of payments due as the result of audits and peer review findings.

- Reconciliation of claims receivables to claims history adjustments.
- Adjustment of benefit or pre-authorization records to reflect any refunds of previously decremented service authorizations.

Clarification: Perform accounts receivable functions to include:

- Collection of overpayments.
- Maintenance of payments due as the result of audits and peer review findings.
- Reconciliation of claims receivables to claims history adjustments.
- Adjustment of benefit or pre-authorization records to reflect any refunds of previously decremented service authorizations.

4.4.34 At minimum, process financial transactions including, but not limited to:

- Accounts receivables.
- Recoupments.
- Manual checks.
- Application of checks received to accounts receivable.
- Application of checks to a payer's payment history file.
- Check stop payment and EFT reversals.
- Check voids and void re-issue and EFT reversals.

Clarification: Process financial transactions for:

- Accounts receivables.
- Recoupments.
- Manual checks.
- Application of checks received to accounts receivable.
- Application of checks to a payer's payment history file.
- Check stop payment and EFT reversals.
- Check voids and void re-issue and EFT reversals.

4.4.35 Establish and maintain financial processing and adjustment processing policies and procedures and posting instructions.

Clarification: These policies must align with the encounter reporting requirements specified in the RFP.

4.4.43 Provide accounting processes for non-claim specific financial transactions (e.g., member share payment collection transactions) including, but not limited to:

- Application of collections received to cash receipts and satisfaction of accounts receivable.
- Application of refunds received to a payer's payment history file, with reconciliation processes to assure all receipts are credited to the historical records.
- Institutional liability amounts owed by recipients.
- Date of service, date of adjudication, date of payment.

Clarification: Provide general accounting processes for non-claim specific financial transactions submitted to the TPA in error (e.g., member share payment collection transactions) including:

- Application of collections received to cash receipts and satisfaction of

- accounts receivable, if applicable.
 - Application of refunds received to a payer's payment history file, with reconciliation processes to assure all receipts are credited to the historical records, if applicable.
 - Institutional liability amounts owed by recipients, if applicable.
 - Date of service, date of adjudication, date of payment.
- 4.4.47 Perform accounts receivable functions to include, but not limited to:
- Collection of member share including cost share, room and board, spend down, and voluntary contributions; and parental payment limit.
 - Tracking spend down limits by recipient.
 - Coordination of member share amounts paid to multiple sources.
- Clarification: Perform accounts receivable functions to include:
- Collection of member share including cost share, room and board, spend down, and voluntary contributions; and parental payment limit.
 - Tracking spend down limits by recipient.
 - Coordination of member share amounts paid to multiple sources.
- 4.5.1 Receive eligibility information in a variety of mediums including, but not limited to, HIPAA-compliant electronic formats, and paper documents.
- Clarification: Receive enrollment information in a variety of mediums including, but not limited to, HIPAA-compliant electronic formats, and paper documents.
- 4.5.2 Maintain recipient data to support processing of long term care claims including, but not limited to:
- Level of Care.
 - Level of Care effective dates.
 - Spend down amount.
 - Recipient location data.
 - Case management unit.
 - County of residence.
 - Specific office locations within a county.
 - County of fiscal responsibility.
- Clarification: This item is eliminated from the Family Care / Family Care Partnership program requirements.
- 4.5.3 Accept HIPAA compliant eligibility/enrollment information from the DHS, contracting organization, and/or CMS as directed by individual agreements.
- Clarification: This requirement has been changed from PMPM to an optional requirement.
- 4.5.4 Provide controls to prevent retroactive adjustments to eligibility and/or enrollment dates. Provide limited override capability with automatic claims and authorization adjustments and/or reports in the event retroactive changes are made.

Clarification: Vendors must provide the specified controls. MCOs have the flexibility to determine how retroactive changes are made.

4.5.5 Maintain recipient eligibility status including enrollments and disenrollments, including dates and reasons. There may be multiple entries for one recipient.

Clarification: Maintain recipient enrollment status including enrollments, disenrollments, dates and reasons. There may be multiple entries for one recipient.

4.5.7 Accept and process claims based on enrollment dates that occur on the date of eligibility rather than the first of the month.

Clarification: Accept and process claims based enrollment dates that occur on the date of eligibility rather than the first of the month.

4.5.8 Provide enrollment reports calculating enrollment days for programs which enroll on the eligibility date, versus the first of the month.

Clarification: This applies to enrollment based on actual enrollment date, versus the first of the month.

4.5.9 Accommodate the capture of county of fiscal responsibility as an enrollment data element, which may change over the course of a program enrollment period.

Clarification: This item is eliminated from the Family Care / Family Care Partnership program requirements.

4.6.2 Capture, and provide access to, prior authorization data which includes, at minimum, the following:

- Prior authorization number.
- Recipient information.
- Service Information, including: requested start date, rendering provider number, coding information, modifiers, place of service, description of service, quantity authorized, quantity used, dollar amount charged, begin and expiration date.
- Receive date.
- Date approved.
- Expiration date.
- History of all actions taken, including amendments.
- Date of last change, ID of person changing, and information changed.
- Review date.
- Date adjudication notice sent to provider and recipient.
- Authorizing person identification.
- Free-form text area for special considerations, along with a flag to allow identification of authorizations with special considerations.
- A text area which will be printed on the prior authorization notice, using predefined messages as well as unique messages (e.g., informing providers of cases where the original code requested was changed to

reflect the diagnosis on the authorization).

Clarification: Capture, and provide access to, prior authorization data required to process the claim and provide reports.

4.6.17 Accommodate atypical claim forms used for self directed supports services authorizations and recipient approval or verification of services.

Clarification: This requirement has been changed from PMPM to an optional requirement.

4.6.18 Provide claim review processes to verify recipient approval of services in self directed service situations. Accommodate global recipient approval of services by provider.

Clarification: This requirement has been changed from PMPM to an optional requirement.

4.7.1 Establish a process to track sanctioned providers, accommodating date sensitivity and type of sanction. Obtain information from appropriate federal and state agencies (e.g., CMS, Federal and State Office of Inspector General, Department of Regulation and Licensing and others). Validate and report providers sanctioned at the state or federal level to the contracting organization and/or the DHS.

Clarification: Establish a process to track and report on sanctioned providers, accommodating date sensitivity and type of sanction.

The vendor must have the system capability to track and report. The MCO provider contracting and credentialing entity is responsible for identifying sanctioned providers.

4.7.2 Establish a process to track and maintain long term care facility information including, but not limited to, the following:
- Number of beds (Medicaid and Medicare).
- Level of care.

Clarification: Establish a process to track and maintain long term care facility information that includes the ability to store the Medicare certified beds and facility type.

4.7.3 If required, reconcile information from Medicare carriers and intermediaries or COB Medicare contractors when received and make necessary changes to the Medicare provider information within five (5) business days of receipt of information from the Medicare carriers and intermediaries.

Clarification: Delete this requirement.

4.7.6 Control the ability to apply retroactive changes to provider data. Provide limited override capability with automatic claims and authorization

adjustments and/or reports in the event retroactive changes are made.

Clarification: Vendors must provide the specified controls. MCOs have the flexibility to determine how retroactive changes are made.

4.7.8 Monitor and report the impact of provider file changes on existing authorizations.

Clarification: Vendors are expected to report to the MCO on any authorizations that are impacted by file changes. The vendor is expected to have the capacity for this; MCOS will specify implementation details.

4.7.12 Use state-defined standardized abbreviations for data fields in the provider file.

Clarification: Delete this requirement.

4.7.17 Maintain the contracting organization provider file separately from other lines of business. Maintain the provider data without overlaying it as a result of changes to data received from other lines of business. Provide reports to the contracting organization when new or different data is received, to determine whether changes should be applied to the contracting organization data.

Clarification: Maintain the contracting organization provider data separately from other lines of business. Maintain the provider data without overlaying it as a result of changes to data received from other lines of business.

4.8.3 Generate periodic reports as specified by the contracting organization including, but not limited to:

- Case status.
- Grievance.
- Complaints.
- Appeals counts and information.

Clarification: Support the MCO process by providing reports regarding status and counts of grievances, complaints, and appeals directed to the TPA. MCO has the option to require vendors to provide status reports, as directed by the MCO.

4.9.1 Provide a training plan that identifies activities leading up to, and including, the training of providers and user staff, at all levels, in the proper use of the system and functions performed under this contract. The plan should include a description of the training objectives, methods, schedule, and activities and include details on the feedback and evaluation mechanisms that will be used. Requirements also include:

- Description of training materials.
- Description of training facilities (e.g., use of screens).
- Training schedule.
- Plans for remedial training.
- Methodology to ensure continued training for staff changing positions,

- and new service providers.
- Ongoing evaluation using specified evaluations.

Clarification: Provide this training plan to the Department. Additional requests may be made by the MCO.

4.9.15 Provide call center and help desk services to providers and recipients, or a recipient's authorized representative, regarding claims status as well as assistance for vendor-supplied software or the vendor system use.

Clarification: Provide call center services to recipients, or a recipient's authorized representative.

4.9.18 Track calls and contacts with basic identifying information. The information shall include at a minimum:

- Time and date of call or contact.
- Provider name and identification number.
- Caller name.
- Nature and details of the call or contact.
- Type of inquiry (e.g., phone, written, face to face, internet, email).
- Length of call (for a phone contact).
- Caller's county.
- Customer service correspondent name and identification number.
- Response given by customer service correspondent and the format in which the response was given (e.g., written, telephone, e-mail).
- Status of inquiry (e.g., closed, follow-up needed).
- Capacity for free form text of at least five hundred (500) characters to describe problems and resolutions.

Clarification: Track calls and contacts with basic identifying information. The information shall include:

- Time and date of call or contact.
- Provider name and identification number.
- Caller name.
- Nature and details of the call or contact.
- Type of inquiry (e.g., phone, written, face to face, internet, email).
- Length of call (for a phone contact).
- Caller's county.
- Customer service correspondent name and identification number.
- Response given by customer service correspondent and the format in which the response was given (e.g., written, telephone, e-mail).
- Status of inquiry (e.g., closed, follow-up needed).
- Capacity for free form text of at least five hundred (500) characters to describe problems and resolutions.

This requirement has been changed from an optional requirement to PMPM.

4.9.19 Create extract files or reports that contain summary information on all calls

and contacts received during a specified timeframe.

Clarification: This requirement has been changed from an optional requirement to PMPM.

- 4.9.20 Provide the ability to refer and track calls and contacts to other contracting organization staff for follow-up. When the call or contact is referred, in addition to the basic identifying information, the referral shall include:
- Call or contact priority.
 - Referral date.
 - Resolution due date.
 - Actual resolution date.
 - Referral person.
 - Name and/or identification number of the person resolving the call or contact.
 - Description of the resolution.

Clarification: This requirement has been changed from an optional requirement to PMPM.

- 4.9.21 Establish and maintain inquiry routing and escalation procedures, as specified by contracting organization agreement.

Clarification: This will be defined at the bulletin level, but will need the flexibility to establish MCO-specific contacts.

This requirement has been changed from an optional requirement to PMPM.

- 4.9.26 Research and respond to technical policy, procedure, and pricing questions from providers and recipients, or a recipient's authorized representative.

Clarification: This refers to help desk functions and should be included in the PMPM.

- 4.9.27 Respond to provider inquiries on claims status and payment information including, but not limited to:
- Adjudicated claims.
 - Paid amount.
 - Claim status.
 - Denial reason.
 - Requests for electronic claim status capability.

Clarification: Respond to provider inquiries on claims status and payment information including:

- Adjudicated claims.
- Paid amount.
- Claim status.
- Denial reason.
- Requests for electronic claim status capability.
- Grievance, appeal, and escalation.

This requirement has been changed from an optional requirement to PMPM.

- 4.9.28 Maintain call statistics including but not limited to:
- Time and Date of call.
 - Identifying information on call.
 - Call category.
 - Inquiry description.
 - Response description.
 - Busy.
 - Dropped calls.
 - Call wait time.
 - Length of call.

- Clarification: Maintain call statistics including:
- Time and Date of call.
 - Identifying information on call.
 - Call category.
 - Inquiry description.
 - Response description.
 - Busy.
 - Dropped calls.
 - Call wait time.
 - Length of call.
 - Turnaround time to closure.

This requirement has been changed from an optional requirement to PMPM.

- 4.9.29 Generate, at a minimum, the following types of daily, weekly, and monthly reports:
- Incoming calls and contacts answered.
 - After hours calls and contacts.
 - Cumulative calls and contacts answered.
 - Total calls abandoned.
 - Abandoned or lost rate percent.
 - Average wait time.
 - Average hold time in queue.
 - Call topic.

- Clarification: This requirement has been changed from an optional requirement to PMPM.

- 4.9.30 Deliver cultural diversity training to call and contact management center correspondents.

- Clarification: Deliver cultural diversity training to call and contact management center correspondents, based upon the approved training plan.

This requirement has been changed from an optional requirement to

PMPM.

- 4.10.4 Identify providers with a unique provider number using the National Provider Identifier (NPI), or standards consistent with NPI, and HIPAA requirements. Unique identifier information should include, but is not limited to, all locations, provider types, specialties, authorizations, certifications, licensing for services, and all other appropriate information for that provider as a logical record linked to the unique provider number.

Clarification: Identify providers with a unique provider number using the National Provider Identifier (NPI), or standards consistent with NPI, and HIPAA requirements. Unique identifier information must include all information required to process claims and generate accurate reports.

- 4.10.8 Generate reports on any occurrences of duplicate provider or recipient numbers.

Clarification: Vendors must have the capability to report on duplicates. Notification details will be established by each MCO.

- 4.11.1 Generate required reports as defined by the DHS including, but not limited to:

- Incurred But Not Reported (IBNR).
- Outstanding liability, including from claims and authorizations.
- Obligations based on authorization data.
- Quality of transactions received.
- Authorization trend reports (e.g., recipient consumption, compliance by category of service, by case manager).
- Reports to accommodate estate recovery (e.g., claims and receivables history for deceased recipients).

Clarification: Generate required reports as defined by the Department including:

- Run out reports / claims lag.
- Outstanding liability, unconsumed authorizations.
- Trend reports to assess risk, including:
 - Recipient consumption rate by category of service and by care management team.
 - Authorizations received through the established process, verbal authorizations, claims paid without authorizations.
 - Adjustment trends.

- 4.11.2 Generate claims control reports by program including, but not limited to, the following:
- Invalid transactions.
 - Daily control activity.
 - Adjustments entered.
 - Corrections not applied.
 - Daily batch errors.
 - Inventory and production reports.
 - Daily management summary.
 - Error analysis.
 - Error summary.
 - Aged inventory - location age.
 - Aged inventory - system age.
 - Returned and denied claims.

Clarification: Generate claims control reports by program including:

- Invalid electronic transactions.
- Daily control activity.
- Adjustments entered.
- Data file updates not applied.
- Daily batch errors.
- Inventory and production reports.
- Daily management summary.
- Error analysis.
- Error summary.
- Aged inventory - location age.
- Aged inventory - system age.
- Returned and denied claims.

The vendor must have the capacity to produce these reports. The MCOs have the flexibility to specify details regarding the generation of these reports.

- 4.11.7 Provide a performance dashboard, available to contracting organization staff, by line of business that includes, but is not limited to claims inventory, claims and customer service turn-around time, and quality statistics.

Clarification: Provide a performance dashboard, available to the Department and contracting organization staff, by line of business that includes claims inventory, claims turn-around time, and quality statistics.

- 4.11.10 Generate standard reports as defined by the contracting organization including, but not limited to:
- Open prior authorizations at any point in time.
 - Active prior authorizations versus claims received and processed.
 - Paid, denied, and adjusted claims.
 - Claims trend and analysis reports (e.g., submission times vs. dates of service for run out; lag reports by category of service, provider type).
 - Data entry time lag.

- Claims lag (from date received to date check is mailed).

Clarification: Generate standard reports as defined by the contracting organization including:

- Paid, denied, and adjusted claims.
- Claims trend and analysis reports (e.g., submission times vs. dates of service for run out; lag reports by category of service, provider type).
- Data entry time lag.
- Claims lag (from date received to date check is mailed).

5.1.2 Maintain DRG files to use in pricing inpatient and outpatient hospital claims. Seven (7) years of data must be maintained. The DRG file will contain, at a minimum, elements such as:

- DRG code.
- English translation of code (DRG description).
- Add date.
- Begin date.
- End date.
- DRG weight (relative value).
- Outlier Days (low and high days).
- Audit trail.
- Average length of stay.

Clarification: Maintain DRG files to use in pricing inpatient and outpatient hospital claims. Seven (7) years of data must be maintained. The DRG file will contain elements required to accurately process contracted DRG rates.

5.2.11 Provide for inpatient hospital pricing methodologies including but not limited to:

- DRG grouping.
- DRG with outlier if an outlier is applicable.
- Per diem.
- Days eligible.
- Percentage of charge.
- Other methods specified by contracting organization agreements.

Clarification: Provide for inpatient hospital pricing methodologies including:

- DRG grouping.
- DRG with outlier if an outlier is applicable.
- Per diem.
- Days eligible.
- Percentage of charge.

MCOs may specify additional methods.

- 5.2.12 Apply all outpatient hospital pricing methodologies as well as the ability to bundle certain revenue codes into a flat rate per revenue code.
Outpatient hospital pricing methodologies include but are not limited to:
- Rate per visit.
 - Flat rate per revenue code.
 - Rate per revenue code, service and procedure code, or billed amount (whichever is less).
 - Procedure code, and diagnosis code.
 - Percentage of charge per revenue code.

- Clarification: Apply all outpatient hospital pricing methodologies as well as the ability to bundle certain revenue codes into a flat rate per revenue code.
Outpatient hospital pricing methodologies include:
- Rate per visit.
 - Flat rate per revenue code.
 - Rate per revenue code, service and procedure code, or billed amount (whichever is less).
 - Procedure code, and diagnosis code.
 - Percentage of charge per revenue code.
 - Ambulatory Payment Group (APG).
 - Medicare and Medicaid required Fee For Service methodologies.

- 5.5.6 Perform or subscribe to services for the following operational PBM responsibilities including but not limited to:
- Negotiating supplemental rebates.
 - Maintaining preferred drug list.
 - Reviewing and approving prior authorization requests and criteria.
 - Providing customer service.
 - Quality and patient safety.
 - Formulary management and development.

- Clarification: Perform or subscribe to services for the following operational PBM responsibilities including:
- Negotiating supplemental rebates.
 - Maintaining preferred drug list.
 - Reviewing and approving prior authorization requests and criteria.
 - Providing customer service.
 - Quality and patient safety.
 - Formulary management and development.
 - Negotiating provider pricing.

APPENDIX B - TPA SERVICES COSTS

Clarifications:

“Costs” means all costs required to accomplish the described activities in these sections (e.g., staff time, materials, vendor fees, licensing and/or hosting fees and travel expenses). All vendor costs necessary to deliver the services outlined in the contract and amendments, including the RFP and requirements clarification documents, are covered by this document; and therefore, no separate service costs or payment arrangements for any services outlined in the contract and its amendments will be negotiated by the vendor without prior approval by the Department.

“Claim” means the service encounter documentation submitted by a single provider, for a single member, on a given date, and on a single claim form or as controlled by the vendor internal control number or ICN. Multiple service encounters on a single claim submission are not multiple claims. Conversely, multiple service encounters by a single provider for a single member submitted electronically on a given date are assumed to be separate claims. This excludes adjustments, as they are described in the encounter reporting implementation guide.

“Volume” means the total number of claims processed, and includes the claims of both Family Care and Family Care Partnership programs

“PMPM” means the per member, per month cost for claims handling services. This includes daily enrollments and disenrollments of all members being served each month by the Family Care and Family Care Partnership programs. The PMPM is a monthly amount; however member enrollments and disenrollments are daily and will be charged at the full monthly PMPM rate.

Core Business System Costs

Bulletin Level Development. Based on the responses to the RFP and requirements clarification processes, there will be no programming required and no costs associated with bulletin level development.

Bulletin Level Setup. Bulletin Level Setup is a one time cost for all core functions. Bulletin level requirements are intended to be standardized for all MCOs contracting for these services, therefore the setup costs for these requirements is a Department cost; it will not be a repeated for each MCO. The Bulletin Level Setup cost established for this contract does not affect costs for individual MCO Participating Agreements. Bulletin Level Setup will be paid to the Contractor by the Department, although the Bulletin Level Setup cost will not be paid until an MCO Participating Agreement has been established with the Contractor.

The costs in this section include any setup or configuration work the contractor expects to have to complete, in the applications proposed for use in this contract, and any changes to workflows, communication processes or training plans to meet the business requirements of this section. This cost also includes the cost of establishing user group processes and standard implementation, training, and

communication protocols. Bulletin Level Setup also includes any of the same changes needing to be accomplished by sub-contractors providing services for the contractor.

The contractor must provide a service and system configuration template to be used to establish standard Department setup configurations, allowing the MCO to make decisions on setup only in the areas that have not been standardized in the Bulletin Level Setup. This establishes a standardized baseline system setup or configuration for all MCOs, thus eliminating the need for those organizations to address the standard configuration decisions.

Organizational Level Contracting (MCO). Organization Level Contracting is a one time cost for each MCO that ends with the completion of agreed upon implementation deliverables and the commencement of contractor claims processing related services. Organizational level requirements are outlined in the RFP and clarifications to requirements specified in Appendix A, and may be unique for each MCO contracting for these services.

Organization Level Contracting costs include any setup or configuration work a contractor (or contractor's sub-contractors) must complete in the applications used in this contract, and any changes to workflows, communication processes, or training plans to meet the organizational level business requirements. The cost includes any MCO and provider training necessary to effectively commence contractor services under this Contract. The Organization Level Contracting costs also include any customization of inputs and/or outputs required to administer the MCO contract.

There are no other development or programming changes in this cost. Periodic adjustments to the configurations for program or regulatory requirements changes are covered by the PMPM. Because a significant portion of organization level setup and configuration work has been completed for MCOs that currently contract with a selected contractor, these costs will be reduced for the MCOs for which the contractor currently provides claims processing services.

The Organization Level Contracting costs may be negotiated by the MCO as an hourly rate, not to exceed the rates established for technical services skill sets in the State bulletin for such services, or as a fixed price. The provision of the organizational setup services is subject to a pre-approved implementation plan. The Contractor and the MCO are required to establish and agree upon an implementation plan and pricing prior to commencement of work covered by this RFP. The Department is responsible for reviewing all MCO Participating Agreements to ensure compliance with this Master Agreement.

Additionally, the Department or the MCO may request additional support services (e.g., reports). Such services are to be provided to the Department by the contractor on a flat rate deliverable basis or on an hourly basis. The costs for any of these additional support services will not exceed the rates established for technical services skill sets in the Information Technology Services Sourcing Contract, #15-92040-501, for Data Processing, Computer, and Software Services.

Core Per Member, Per Month Costs (PMPM). The Core PMPM costs are costs for providing services outlined in Section 4.0 of the RFP, and clarifications to the requirements in Appendix A, which are common to both the Family Care and Partnership programs. The Core PMPM includes any combination of Family Care or Partnership business functions and is based on negotiated volumes, and is subject to any other negotiated increases or discounts.

The Core PMPM is based on member enrollment data provided to the contractor by the MCO and covers all claims processing and run out claims based on dates of service, regardless of the status of the contract or member eligibility at the time of claim receipt.

Periodic adjustments to the configurations for program or regulatory requirements changes are covered by the Core PMPM.

The costs for claims-related customer service functions are included as a core service. The cost includes all contractor costs for staff time, ongoing training costs, system use or access costs, materials, contractor fees, application licensing, hosting costs, travel expenses and any other costs not specifically outlined in the Bulletin Level Development, Bulletin Level Setup, Organizational Level Contracting, Optional Functions Contracting, and Additional Business System Costs for Family Care Partnership.

Optional Functions Contracting. The Optional Functions are specified in the RFP requirements and clarifications to requirements in appendix A. MCOs have the flexibility to determine which optional functions are relevant to their individual business operations, and will negotiate the costs for these optional functions directly with the contractor. The provision of any of these optional services is subject to a pre-approved implementation plan and service level agreement for deliverables.

The Optional Functions costs include all setup or configuration needed by the contractor and any sub-contractors, if any, to meet the RFP requirements and clarifications to requirements in Appendix A, and any customization of inputs and/or outputs required to provide the optional service. The setup cost is a one time cost for each MCO that ends with the completion of agreed upon implementation deliverables and/or the commencement of contractor services. The Optional Functions costs may also include the costs for providing services for the requirements outlined in this section.

Additional Business System Costs for Family Care Partnership

Additional Per Member, Per Month. The PMPM cost in this section covers only the functions outlined as additional requirements for the Family Care Partnership program. This is an add-on to the Core PMPM. This PMPM is based on member enrollment data provided to the vendor by the contracting organization and to cover all claims processing and run out claims based on dates of service, regardless of the status of the contract or member eligibility at the time of claim receipt. The contractor must consider the claims processing cost implications associated with the requirements for Medicare integrated enrollment and disenrollment processes in this PMPM.

Other Anticipated Increases or Discounts. The Department may wish to negotiate volume discounts for this contract. In the event that volume discounts are negotiated, it is assumed that the volumes considered are for any combination of Family Care or Partnership business and the reduction will impact the Core PMPM.

Service Costs

Core Business System Costs

Bulletin Level Development.	\$ 0.00	
Bulletin Level Setup.	\$ 50,000.00	
Core Per Member, Per Month Costs (PMPM).	\$ 16.90	PMPM
Organizational Level Contracting, per MCO. Negotiated with each MCO.		
MCO Optional Functions Contracting. Negotiated with each MCO.		

Additional Business System Costs for Family Care Partnership

Additional Per Member Per Month.	\$ ----.--	PMPM
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Establishment of the additional business system costs for Family Care Partnership is dependent on an evaluation of policies regarding pharmacy rebates by the Department. A contract addendum will be negotiated to establish this cost, once the Department evaluation is complete.

Other Anticipated Increases or Discounts.

None.	\$ 0.00	PMPM
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