STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

March 28, 2013

Lucian Geise, Director
Fiscal Review Committee
8th Floor, Rachel Jackson Bldg.
Nashville, TN 37243

Attention: Ms. Leni Chick

RE: MCO Contract Amendments - (7)
HP Enterprise Services, LLC (formerly EDS) - Amendment #1
Oregon Health and Science University – Center for Evidence Based Policy

Dear Mr. Geise:

The Department of Finance and Administration, Division of Health Care Finance and Administration, is submitting for consideration by the Fiscal Review Committee the following Managed Care Organization (MCO) amendments. The MCO contracts provide medical and behavioral health services to TennCare enrollees. The proposed amendment contains the following language updates: (1) Revises requirements around circumstances necessitating member signature on the CHOICES Plan of Care; (2) Adds language regarding ADA requirements; (3) Clarifies Member Material Requirements and adds an Annual Evaluation of MCO Outreach Plans; (4) Adds clarity around CHOICES requirements to secure accurate address/contact information; (5) Adds clarity around emergency plans for CHOICES enrollees; (6) Updates CHOICES Caseload requirements; (7) Updates language to reflect Group 3 CHOICES members are not eligible for MFP; (8) Revises Pay for Performance Language to allow TennCare to choose future benchmarks based on specific MCO needs for improvement; (9) Adds language to facilitate pass-through of pharmacy costs to the pharmacy benefits manager, and (10) Additional contract language clarifications to update references regarding Individuals with Intellectual Disabilities. No funds are required to support the changes in this amendment.

Volunteer State Health Plan (TennCare Select)	FA-02-14632-32
AMERIGROUP Tennessee, Inc.	FA-07-16936-15
UnitedHealthCare Plan of the River Valley, Inc.	FA-07-16937-15
UnitedHealthCare Plan of the River Valley, Inc (West Region)	FA-08-24979-12
Volunteer State Health Plan (West Region)	FA-08-24978-12
UnitedHealthCare Plan of the River Valley, Inc. (East Region)	FA-08-24984-12
Volunteer State Health Plan (East Region)	FA-08-24983-12

Also submitted for review is amendment #1 to HP Enterprise Services, LLC (formerly EDS). This contract is for the operation, management, and enhancement of the TennCare Management Information Systems. This amendment is to continue system management by execution of term extension, provide new enhancements and projects, and provide funding to support the term extension of the contract. These projects include Service Oriented Architecture infrastructure, in support of Modularity (1 of the 7 new CMS Standards and Conditions for enhanced Federal Financial Participation); Enterprise Provider Portal framework to promote provider self-service and strengthen the framework for provider access security management; extension of ICD-10 deployment project based on revised CMS schedule, and provide supplemental support for extensive system changes related to federal mandates.

Finally, TennCare is requesting approval of a non competitive contract with Oregon Health and Science University, Center for Evidence Based Policy. The Contractor organizes and administers the Medicaid Evidence-Based Decisions (MED) Project and the Drug Effectiveness Review Project (DERP) to create an effective collaboration among Medicaid programs and their state partners for the purpose of making high quality evidence analysis available to support benefit design and coverage decisions made by state programs to align goals and resources that enable states to achieve results and impact policy they may be unable to achieve individually. Oregon Health & Science University, Center for Evidence-Based Policy (CEBP), is the sole provider of Medicaid focused collaboratives, related to the specific areas of diagnostics, devices, programs, procedures, and medications, founded to produce evidence reports for its members and explicitly governed by the members themselves. Because of CEBP's status as the sole provider of these unique services and the specific expertise and resources provided through this collaboration, contracting with CEBP is considered to be in the best interest of the State.

The Department of Finance and Administration, Division of Health Care Finance and Administration, appreciates consideration of these amendments by the Fiscal Review Committee and respectfully requests approval.

Sincerely,

Casey Dungan
Chief Financial Officer

cc: Darin J. Gordon, Deputy Commissioner
Alma Chilton, Director of Contracts

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Casey Dungan	*Contact Phone:	507-6482
*Original Contract Number:	FA1028520	*Original RFS Number:	31865-00080
Edison Contract Number: *(if applicable)*	12056	Edison RFS Number: *(if applicable)*	
*Original Contract Begin Date:	July 1, 2009	*Current End Date:	June 30, 2013
Current Request Amendment Number: *(if applicable)*		#1	
Proposed Amendment Effective Date: *(if applicable)*		June 1, 2013	
*Department Submitting:		Finance and Administration	
*Division:		Division of Health Care Finance and Administration Bureau of TennCare	
*Date Submitted:		March 28, 2013	
*Submitted Within Sixty (60) days:		Yes	
If not, explain:			
*Contract Vendor Name:		HP Enterprise Services, LLC	
*Current Maximum Liability:		$170,662,054.00	

*Current Contract Allocation by Fiscal Year:
(as Shown on Most Current Fully Executed Contract Summary Sheet)

FY: 2010	FY: 2011	FY: 2012	FY: 2013	FY	FY
$50,052,305.00	$42,296,342.00	$38,621,618.00	$39,691,789.00	$	$

*Current Total Expenditures by Fiscal Year of Contract:
(attach backup documentation from STARS and Edison – Attached)

FY: 2010	FY: 2011	FY: 2012	FY: 2013	FY	FY
$24,533,666.23	$36,500,971.79	$40,130,543.97	$30,147,555.42 **(Thru January/2013)**	$	$

IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:	This contract payment methodology is based on fixed rates as well as milestone rates based on completion of work product. The maximum liability is calculated by FY to include the projected expenditures based on need for contractor's services and programmatic need within the Bureau of TennCare. Any milestones that were not completed during the projected Fiscal Year funding rolled forward for available funding use upon completion of deliverables.
IF surplus funds have been carried forward, please give the reasons	If the amount spent on this contract is less than the budgeted amount and contributes to a

Supplemental Documentation Required for Fiscal Review Committee

and provide the authority for the carry forward provision:	net surplus for the bureau, surplus funds would be carried forward subject to authority granted in Section 48, Item 3 of the General Appropriations Act.			
IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:	N/A			
*Contract Funding Source/Amount:	State:	$40,754,664.00	Federal:	$129,907,390.00
Interdepartmental:			*Other*:	
If "*other*" please define:				
Dates of All Previous Amendments or Revisions: (*if applicable*)	Brief Description of Actions in Previous Amendments or Revisions: (*if applicable*)			
	N/A			
Method of Original Award: (*if applicable*)	Non Competitive (RFP winning Proposer and TennCare mutually agreed to terminate contract. HP (EDS) was proposer with 2nd highest RFP score)			
*What were the projected costs of the service for the entire term of the contract prior to contract award?	$170,662,054.00 (Based on combination of negotiated rates and rates submitted in original RFP Cost Proposal)			

Supplemental Documentation Required for Fiscal Review Committee

For all new non-competitive contracts and any contract amendment that changes Sections A or C.3. of the original or previously amended contract document, provide estimates based on information provided the Department by the vendor for determination of contract maximum liability. Add rows as necessary to provide all information requested.

If it is determined that the question is not applicable to your contract document attach detailed explanation as to why that determination was made.

Planned expenditures by fiscal year by deliverable. Add rows as necessary to indicate all estimated contract expenditures.

C.3. Payment Methodology

The Contractor shall be compensated based on the payment rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1.

a) The Contractor's compensation shall be contingent upon the satisfactory completion of units, milestones, or increments of service defined in Section A.

b) The Contractor shall be compensated for said units, milestones, or increments of service based upon the rates as defined in Section C.3.

c) Pass-Through Cost Payments—The State shall reimburse the Contractor for pass-through costs pre-approved by the State, on the basis of actual cost. Pass-through costs shall not include any overhead, administrative, or other fee or commission. The Contractor shall petition the State for a reimbursement of pass-through costs on a monthly basis, in addition to the regular invoice for professional services provided pursuant to this Contract. The monthly petition for reimbursement of pass-through costs shall include substantiating documentation and the pre-approval by the State. Services reimbursed on a pass-through basis include postal related (i.e., postal services, postage and postal supplies); and third party vendor services (i.e., translation, Edifecs, SunGard, Avaya, and First DataBank). Contractor shall make payment to the Bureau approved postal carrier (the US Postal Service) or the administrator of the Bureau postage meters (the US Postmaster and Pitney Bowes) on behalf of the Bureau; however, the Contractor shall have no responsibility for the delivery by the postal carrier to an addressee. Invoicing for postage meters shall be based on the funds paid to replenish the meter, less a credit for any Contractor postage in the prior period. Pass-through postage costs do not include Contractor postage for Contractor business operations.

d) Professional Service Payments—The State shall compensate the Contractor based on the Service Rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1.

e) Special Projects Staffing compensation shall be based on the Payment Rates detailed in the Contractor's excess staffing proposal multiplied by the units of service authorized by the Bureau. The Bureau shall compensate the Contractor for Project work based on the hourly rates detailed in the Contractor's excess staffing proposal. The Contractor shall submit monthly invoices, in form and substance agreed to with the Bureau with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall, at a minimum, include the name of each individual, the individual's job title, the number of hours worked during the period, the applicable Payment Rate, the total compensation requested for the individual, and the total

amount due the Contractor for the period invoiced.

f) Hardware, Software and Maintenance – The State may request the contractor purchase licenses or maintenance for hardware and software for the TCMIS. The State shall reimburse the Contractor for hardware and software products and maintenance purchased by request of the State based on the actual cost plus an administrative fee in the amount of twenty-one percent (21%) of the actual cost. The Contractor shall petition the State for a reimbursement of maintenance costs on a monthly basis, in addition to the regular invoice for professional services provided pursuant to this Contract, and any and all amendments thereto. The monthly petition for reimbursement of maintenance costs shall include substantiating documentation.

The Contractor shall submit invoices no more often than monthly, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Such invoices shall be submitted for completed project milestones for the amount stipulated.

C.3.1. Assessment Pricing Details

The Contractor shall be compensated "per assessment/deliverable" during the Transition and Implementation Phase of this Contract. The Contractor shall be compensated in accordance with the fixed prices for each assessment/deliverable set forth in this Contract listed in the table labeled "Transition and Implementation Pricing Detail". Total Transition and Implementation Fixed Prices shall factor in all related costs and overhead (e.g., Salaries & Benefits, Travel, Administrative Overhead).

Assessment Pricing Detail Table follows:

Item #	Line Item Description	Fixed Price
1	Assessment 1 – MAR Assessment Section A.2.1.1	$142,881
2	Assessment 2 – ICD-10 Assessment Section A.2.1.2	See Below

ICD-10 Design (further defined in A.2.1.2) reimbursement shall be based on the Payment Rates detailed in C.3.4 Special Projects Staffing for units of service authorized by the State. The Contractor shall submit monthly invoices, in form and substance agreed to with the State with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall, at a minimum, include the name of each individual, the individual's job category, the number of hours worked during the period, the applicable Payment Rate, the total compensation requested for the individual, and the total amount due the Contractor for the period invoiced.

The maximum total fees for ICD-10 Design shall be one million one hundred thousand ninety eight thousand and nine hundred thirty eight dollars ($1,198,938.00). The Bureau may roll any residual funds that are unused for Phase 1 to ICD-10 Remediation (Phase 2) construction, configuration, testing and deployment activities.

C.3.2. Pricing of Major System Enhancements

The Contractor shall be compensated "per enhancement" to complete the TCMIS System Enhancements shown in the Request for Proposals. The Contractor shall be compensated in accordance with the fixed prices for each enhancement set forth in the Contract listed in the table labeled, Pricing of TCMIS System Enhancements. Total Enhancement Fixed Prices will already

factor in all related costs and overhead (e.g., Salaries & Benefits, Travel, and Administrative Overhead).

Pricing of TCMIS System Enhancements

Item #	Line Item Description	*Fixed Price
E1	CMMI Level 2 Appraisal (Contract Section A.2.3)	
	Total Enhancement #1	$1,152,723
E1.1	CMMI Level 3 Appraisal (Contract Section A.2.3)	
	Total Enhancement #1.1	$1,353,196
E2	Technology Modernization (Contract Section A.2.4)	
	Total Enhancement #2	$4,681,343
E3	Implement PMO (Contract Section A.2.5)	
	Total Enhancement #3	$1,003,102
E4	Implement a COTS Dashboard (Contract Section A.2.6)	
	Total Enhancement #4	$553,840
E5	Implement a COTS Documentation software (Contract Section A.2.7)	
	Total Enhancement #5	$2,145,937
E6	Implement Enhanced Test Environment (Contract Section A.2.8)	
	Total Enhancement #6	$2,017,656
E7	Conduct Business Process Improvement (Contract Section A.2.9)	
	Total Enhancement #7	$2,530,716
E8	Implement Long-Term Care CHOICES (Contract Section A.2.10)	
	Total Enhancement #8	See Below

Enhancements #1 and #1.1 monthly invoices shall be in an amount equal to the maximum amount per enhancement detailed above divided by the number of calendar months in the subject period. The Bureau shall require retention of payment in the amount equal to fifteen percent (15%) of each monthly invoice for Enhancements #1 and #1.1. This retention of payment shall be held until the satisfaction of the final deliverable of the certification objective for that enhancement. Enhancement #2 reimbursement shall be the maximum amount detailed above and allocated to the Bureau's acceptance of the following key deliverables, as follows.

1. Infrastructure Enhancements Installed (A.2.4.4.3 and A.2.4.4.4) = $2,955,125
2. Data Warehouse Enhancements Installed (A.2.4.4.5) = $1,631,763
3. Oracle Financial Transition Plan Accepted (A.2.4.4.6) = $17,870
4. Security Risk Assessment Accepted (A.2.4.4.7) = $ 76,585

Enhancement #3 reimbursement shall be made in lump sum on acceptance by the State of the base PMO standards, structures and staffing.
Enhancements # 4, #5 and #6 shall be made in lump sum upon acceptance by the State and implementation in production.
Enhancement #7 reimbursement shall be in an amount equal to the maximum amount for this enhancement detailed above divided by the number of MITA key business areas targeted by this enhancement, as referenced in A.2.9 and confirmed by the Bureau in the project planning process. Reimbursement for each business area shall be payable upon Bureau acceptance of the plan for the business processes, including mutually agreed upon process transformations and internal publication of the associated process documentation.
Enhancement #8 reimbursement shall be based on the Payment Rates detailed in C.3.4 Special Projects Staffing for units of service authorized by the State. The Contractor shall submit monthly invoices, in form and substance agreed to with the State with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall, at a minimum, include the name of each individual, the individual's job category, the number of hours worked during the period, the applicable Payment Rate, the total compensation requested for the individual, and the total amount due the Contractor for the period invoiced. The maximum total fees for Long-Term Care (LTC) CHOICES shall be one million nine hundred eighty six thousand two hundred fifty one dollars ($1,986,250.00). The Bureau may roll any residual funds that are unused for LTC CHOICES to ICD-10 Remediation (Phase 2) construction, configuration, testing and deployment activities.

C.3.3. Operations Costs (TCMIS)
Pricing Schedule C1, Item #1 indicates the contracted base rate for operations of the TCMIS, excluding enhancements. Operations compensation shall be based on the Base Rate amounts detailed below for units of service authorized by the State. The Contractor shall submit monthly invoices, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Said monthly invoices shall be in an amount equal to the maximum amount per period detailed below divided by the number of calendar months in the subject period (the divisor shall be twelve (12) after the first period of service).
If, for any reason, the Contractor does not fully meet the operational start date for any of the TCMIS processes and a Contract amendment delaying this date or start-up of a portion of the processing requirements listed has not been approved, then the Contractor shall be liable for costs incurred by the Bureau to continue current operations. Additionally, the Contractor shall forfeit any claims to reimbursement of monthly operations payments for that month and each month thereafter until the Bureau approves operational readiness.
Pricing Schedule C2, Item #1 indicates the contracted incentive rate. The incentive payment shall be paid based on the Contractor receiving a Quality and Customer Service score greater than or equal to eighty-six (86). The Contractor shall receive one hundred percent (100%) of the incentive payment for scores above ninety-three (93). However, the Contractor shall only receive a fifty percent (50%) incentive payment for scores between eighty-six (86) and ninety-three (93).
Pricing schedule C3, Items E1 – E7 shall indicate the contracted rates, if any, for the ongoing operational costs that may be expected for each of the enhancements.

Pricing Schedule C1
Operations Costs – Base Rate (TCMIS)

Supplemental Documentation Required for Fiscal Review Committee

		Fixed Cost				
Item #	Line Item Description	Operational Year 1 (7/1/2009 – 06/30/2010)	Operational Year 2 (7/1/2010 – 06/30/2011)	Operational Year 3 (7/1/2011 – 06/30/2012)	Operational Year 4 (7/1/2012 – 06/30/2013)	Average
1	Base Rate	$22,270,718	$22,424,491	$23,029,219	$23,662,012	$22,846,610

Pricing Schedule C2

Operations Costs – Incentive Rate (TCMIS)

		Fixed Cost				
Item #	Line Item Description	Operational Year 1 (7/1/2009 – 06/30/2010)	Operational Year 2 (7/1/2010 – 06/30/2011)	Operational Year 3 (7/1/2011 – 06/30/2012)	Operational Year 4 (7/1/2012 – 06/30/2013)	Average
1	Incentive Rate	$3,300,000	$3,300,000	$3,500,000	$3,500,000	$3,400,000

Pricing Schedule C3

Operations Costs – Enhancement Operations (TCMIS)

		Fixed Cost			
Item #	Line Item Description	Operational Year 1 (7/1/2009 – 06/30/2010)	Operational Year 2 (7/1/2010 – 07/30/2011)	Operational Year 3 (7/1/2011 – 06/30/2012)	Operational Year 4 (7/1/2012 – 06/30/2013)
E1	Operations costs associated with maintaining CMMI Level 2 Appraisal	$0	$0	$0	$0
E1.1	Operations costs associated with maintaining CMMI Level 3 Appraisal	$0	$0	$0	$0
E2	Operations costs associated with Technology Modernization		$2,400,000	$2,472,000	$2,546,160
E3	Operations costs associated with PMO	$443,012	$547,563	$563,990	$580,909
E4	Operations costs associated with the COTS Dashboard	$0	$283,660	$292,169	$300,934

E5	Operations costs associated with the COTS Documentation software	$0	$30,258	$31,165	$32,100
E6	Operations costs associated with the Enhanced Test Environment	$21,409	$132,307	$136,276	$140,364
E7	Operations costs associated with Business Process Improvement	$0	$0	$158,190	$162,936
E8	Operations costs associated with LTC CHOICES	$0	$0	$0	$0

C.3.4. Special Projects Staffing

Staffing for Special Projects (further defined in Contract Section A.6) compensation shall be based on the Payment Amounts detailed below for any staffing needs in excess of the contracted staffing levels, as authorized by the Bureau. The State shall compensate the Contractor for Change Order work based on the hourly rates below, in a total amount for each change request not to exceed the written estimate agreed upon by the State and the Contractor. The Contractor shall submit invoices no more often than monthly, in form and substance agreed to with the Bureau with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall be submitted for completed units of service for the amount stipulated. NOTE: The Contractor shall not be compensated for travel time to the primary location of service provision.

CATEGORY	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE
	7/01/2009 - 6/30/2010	7/01/2010 - 6/30/2011	7/01/2011- 6/30/2012	7/01/2012 - 6/30/2013
Information Specialist - Senior	$103.56	$106.67	$109.87	$113.16
Information Specialist	$80.00	$82.40	$84.87	$87.42
Information Analyst	$57.14	$58.85	$60.62	$62.44
Information Associate	$52.08	$53.64	$55.25	$56.91
Business Services Analyst - Senior	$71.56	$73.71	$75.92	$78.20
Business Services Analyst - Advanced	$60.72	$62.54	$64.42	$66.35
Business Services Analyst	$55.00	$56.65	$58.35	$60.10
Technical Delivery Team Manager	$91.93	$94.69	$97.53	$100.45
Project Manager	$95.75	$98.62	$101.58	$104.63
Project Analyst - Senior	$85.00	$87.55	$90.18	$92.88
Project Analyst - Advanced	$75.00	$77.25	$79.57	$81.95

Project Analyst	$65.00	$66.95	$68.96	$71.03
Data Base Administrator	$83.75	$86.26	$88.85	$91.52
Data Base Associate	$68.26	$70.31	$72.42	$74.59
Infrastructure Specialist Senior	$96.53	$99.43	$102.41	$105.48
Systems Administrator - - Advanced	$68.26	$70.31	$72.42	$74.59
Systems Administrator	$56.82	$58.52	$60.28	$62.09
Systems Administrator - Associate	$50.00	$51.50	$53.05	$54.64
Computer Operator	$35.00	$36.05	$37.13	$38.25
QA Specialist - Advanced	$70.00	$72.10	$74.26	$76.49
QA Specialist	$55.00	$56.65	$58.35	$60.10
Documentation Project Manager	$70.00	$72.10	$74.26	$76.49
Technical Writer	$45.00	$46.35	$47.74	$49.17
Specialized Support Clerk	$35.00	$36.05	$37.13	$38.25
General Support Clerk	$20.00	$20.60	$21.22	$21.85
Change Management Coordinator	$65.00	$66.95	$68.96	$71.03
Release Coordinator	$65.00	$66.95	$68.96	$71.03
Work Planner	$65.00	$66.95	$68.96	$71.03

C.3.4. Excess Operations Transactions

Excess Operations Transactions compensation shall be based on the Payment Amounts detailed below for any transaction units in excess of the contracted requirement, as authorized by the Bureau. The Contractor shall submit invoices no more often than quarterly in form and substance agreed to with the State with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall be submitted for completed units of service for the amount stipulated.

TRANSACTION TYPE	FIXED FEE PER TRANSACTION			
	07/01/2009 06/30/2010	07/01/2010 – 06/30/2011	07/01/2011 – 06/30/2012	07/01/2012 – 06/30/2013
Suspense Transactions	$0.88	$0.88	$0.89	$0.89

Note:

Excess Suspense Transactions is defined as suspended claims needing resolution activities. Excess suspense transactions shall be determined when the number of suspended claims needing resolution exceeds an average of twelve thousand (12,000) per week for a twelve (12) week period. If the inventory exceeds this total, then the Contractor shall be eligible for reimbursement of excess operations and/or excess staffing that will be needed to facilitate these transactions. The Contractor shall provide sufficient supporting documentation to obtain Bureau approval for reimbursement of the excess transaction costs.

Supplemental Documentation Required for Fiscal Review Committee

Proposed savings to be realized per fiscal year by entering into this contract. If amendment to an existing contract, please indicate the proposed savings to be realized by the amendment. Add rows as necessary to define all potential savings per deliverable.

The HP Enterprise Services, LLC contract is for provision of operation and enhancement of the TennCare Management Information Systems. This amendment does not reflect a savings to the State, however, it continues the existing system for the Bureau of TennCare, which would be costly to re-procure and re-build the system. Components of this system are reimbursed at different levels of federal support: 90%, 75% and 50% determined by functionality being paid.

Comparison of cost per fiscal year of obtaining this service through the proposed contract or amendment vs. other options. List other options available (including other vendors), cost of other options, and source of information for comparison of other options (e.g. catalog, Web site). Add rows as necessary to indicate price differentials between contract deliverables.

The state released a Request for Proposal to identify a contractor to provide TennCare Management Information Systems. Another vendor was awarded the contract, however, due to a mutual agreement between the Contractor and TennCare that the contract was terminated prior to transition from HP, the incumbent contractor. HP was the incumbent contractor and also the proposer with 2nd highest RFP score, so a non competitive contract was executed. The rates and milestone amounts were based on combination of negotiated rates and rates submitted in original RFP Cost Proposal.

FUNDING REVISION

CONTRACT

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

Begin Date	End Date	Agency Tracking #	Edison Record ID
July 1, 2009	June 30, 2013	31865-00080	12056

Contractor Legal Entity Name	Edison Vendor ID
Electronic Data Systems, LLC (HP Enterprises)	68107

Service Caption (one line only)

FUNDING REVISION: $4,000,000.00 moved from FY 2012 50/50 Funding Split (Speed Chart TN00000138) to FY 2012 90/10 Funding Split (Speed Chart TN00000140) and $4,000,000.00 from FY 2013 50/50 Funding Split (Speed Chart TN00000138) to FY 2013 90/10 Funding Split (Speed Chart TN00000140) – See attached Contract Summary Sheet Supplemental

Subrecipient or Vendor

☐ Subrecipient ☒ Vendor

CFDA #

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2010	$11,482,397.00	$38,569,908.00			$50,052,305.00
2011	$10,984,187.00	$31,312,155.00			$42,296,342.00
2012	$9,009,881.00	$29,611,737.00			$38,621,618.00
2013	$9,278,199.00	$30,413,590.00			$39,691,789.00
TOTAL:	$40,754,664.00	$129,907,390.00			$170,662,054.00

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

Ownership/Control

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

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

☐ RFP	The procurement process was completed in accordance with the approved RFP document and associated regulations.
☐ Competitive Negotiation	The predefined, competitive, impartial, negotiation process was completed in accordance with the associated, approved procedures and evaluation criteria.
☐ Alternative Competitive Method	The predefined, competitive, impartial, procurement process was completed in accordance with the associated, approved procedures and evaluation criteria.
☒ Non-Competitive Negotiation	The non-competitive contractor selection was completed as approved, and the procurement process included a negotiation of best possible terms & price.
☐ Other	The contractor selection was directed by law, court order, settlement agreement, or resulted from the state making the same agreement with all interested parties or all parties in a predetermined "class."

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

Speed Chart (optional) See Attached

Account Code (optional) 70803000

OCR USE - FA

Contract # **FA1028520-00**

Electronic Data Systems / HP Enterprise Services
EDISON CONTRACT #12056
CONTRACT PAYMENTS BY FISCAL YEAR
(Payment Detail Attached)

FY2010 (Pre-Edison)	$236,872.57	
FY2010 Edison	$24,296,793.66	
FY 2010 Total	$24,533,666.23	
FY2011	$36,500,971.79	
FY2012	$40,130,543.97	
FY2013	$30,147,555.42	(Through January 2013)
TOTAL	**$131,312,737.41**	

FY2010 Pre-Edison (STARS) Payments

Invoice	Date	Sum Amount
U2499041	8/24/2009	$228,116.17
U2499042	8/24/2009	$296.62
U2499043	8/24/2009	$2,065.08
U2499044	8/24/2009	$587.50
U2499045	8/24/2009	$5,807.20

FY2010 Total		
Pre-Edison Payments	$	236,872.57

FY2010 Edison Payments

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2010	0000068107	00002870	U2499296	10/6/2009	$1,004.00
2010	0000068107	00002867	U2499294	10/7/2009	$3,086.05
2010	0000068107	00002866	U2499295	10/7/2009	$31,500.00
2010	0000068107	00002869	U2500742	10/7/2009	$171,433.03
2010	0000068107	00002868	U2499293	10/7/2009	$1,855,893.16
2010	0000068107	00004767	U2514530	10/9/2009	$1,855,893.16
2010	0000068107	00004768	U2514531	10/21/2009	$3,086.05
2010	0000068107	00004769	U2514532	10/21/2009	$31,500.00
2010	0000068107	00011432	U2516985	10/29/2009	$192,761.97
2010	0000068107	00011433	U2516984	11/5/2009	$144,937.51
2010	0000068107	00015250	U2529753	11/6/2009	$1,855,893.16
2010	0000068107	00015254	U2529756	11/17/2009	$2,987.57
2010	0000068107	00015253	U2529754	11/17/2009	$3,086.05
2010	0000068107	00015251	U2529755	11/17/2009	$31,500.00
2010	0000068107	00020204	U2543978	12/4/2009	$2,402.10
2010	0000068107	00020201	U2543976	12/4/2009	$3,086.05
2010	0000068107	00020209	U2543979	12/4/2009	$5,600.00
2010	0000068107	00020203	U2543977	12/4/2009	$31,500.00
2010	0000068107	00020198	U2543975	12/4/2009	$1,855,893.16
2010	0000068107	00050097	U2548368	1/13/2010	$3,086.05
2010	0000068107	00054439	U2548370	1/13/2010	$6,971.10
2010	0000068107	00054438	U2548369	1/13/2010	$31,500.00
2010	0000068107	00050094	U2546370	1/13/2010	$140,659.29
2010	0000068107	00050093	U2544922	1/13/2010	$142,881.00
2010	0000068107	00050095	U2548367	1/13/2010	$1,855,893.16
2010	0000068107	00054450	U2546371	1/14/2010	$171,656.44
2010	0000068107	00071703	U2569985	2/10/2010	$3,086.05
2010	0000068107	00071704	U2569986	2/10/2010	$31,500.00
2010	0000068107	00071701	U2569983	2/10/2010	$1,855,893.16
2010	0000068107	00071783	U2569987	2/11/2010	$501.00
2010	0000068107	00071788	U2569988	2/16/2010	$68,424.79
2010	0000068107	00080793	U2559267	2/25/2010	$130,400.24
2010	0000068107	00080794	U2571388	2/25/2010	$143,219.46
2010	0000068107	00085546	U2583127	3/8/2010	$3,086.05
2010	0000068107	00090070	U2583130	3/9/2010	$3,671.71
2010	0000068107	00090071	U2583132	3/9/2010	$20,800.00
2010	0000068107	00090069	U2583129	3/9/2010	$31,500.00

FY2010 (Continued)

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2010	0000068107	00090072	U2583131	3/10/2010	$42,698.43
2010	0000068107	00094526	U2584935	3/18/2010	$82,990.60
2010	0000068107	00094525	U2583135	3/18/2010	$260,956.62
2010	0000068107	00094560	U2584936	3/23/2010	$7,800.04
2010	0000068107	00094561	U2583136	3/23/2010	$31,057.04
2010	0000068107	00094562	U2584934	3/23/2010	$130,648.96
2010	0000068107	00108126	U2597775	4/9/2010	$98,067.33
2010	0000068107	00085545	U2583125	4/12/2010	$1,855,893.16
2010	0000068107	00108131	U2597128	4/14/2010	$492.00
2010	0000068107	00108129	U2597126	4/14/2010	$3,086.05
2010	0000068107	00112442	U2597768	4/14/2010	$6,533.72
2010	0000068107	00108130	U2597127	4/14/2010	$31,500.00
2010	0000068107	00108132	U2597129	4/14/2010	$58,419.73
2010	0000068107	00112443	U2597772	4/14/2010	$119,406.28
2010	0000068107	00108128	U2597125	4/14/2010	$1,855,893.16
2010	0000068107	00112441	U2598367	4/15/2010	$222,685.13
2010	0000068107	00120653	U2611644	5/4/2010	$1,778,893.16
2010	0000068107	00120958	U2610769	5/17/2010	$3,086.05
2010	0000068107	00120964	U2610771	5/17/2010	$5,644.63
2010	0000068107	00120960	U2610770	5/17/2010	$31,500.00
2010	0000068107	00120963	U2610772	5/17/2010	$64,181.57
2010	0000068107	00141615	U2625179	6/3/2010	$1,292.00
2010	0000068107	00141613	U2625177	6/3/2010	$3,086.05
2010	0000068107	00141614	U2625178	6/3/2010	$31,500.00
2010	0000068107	00141611	U2625186	6/3/2010	$44,537.02
2010	0000068107	00141616	U2625180	6/3/2010	$49,815.63
2010	0000068107	00141610	U2625184	6/3/2010	$423,911.70
2010	0000068107	00141612	U2625176	6/3/2010	$1,855,893.16
2010	0000068107	00149741	U2613353	6/23/2010	$14,696.12
2010	0000068107	00157320	U2638594	6/30/2010	$1,274.90
2010	0000068107	00157318	U2638591	6/30/2010	$3,086.05
2010	0000068107	00157314	U2627715	6/30/2010	$17,242.04
2010	0000068107	00157319	U2638593	6/30/2010	$31,500.00
2010	0000068107	00157313	U2627713	6/30/2010	$37,101.37
2010	0000068107	00157308	U2613352	6/30/2010	$49,161.98
2010	0000068107	00157321	U2638596	6/30/2010	$75,982.99
2010	0000068107	00157311	U2613354	6/30/2010	$148,114.25
2010	0000068107	00157312	U2530912	6/30/2010	$188,962.03

FY2010 (Continued)

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2010	0000068107	00157317	U2638590	6/30/2010	$1,855,893.16
2010	0000068107	00157310	U2613351	7/1/2010	$44,537.03

FY2010 Total Edison Payments **$24,296,793.66**

FY2011 Payments

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2011	0000068107	00164520	U2627718	7/15/2010	$166,896.78
2011	0000068107	00166614	U2652440	7/29/2010	$1,549.92
2011	0000068107	00166609	U2652442	7/30/2010	$23,638.56
2011	0000068107	00166611	U2652444	7/30/2010	$27,270.98
2011	0000068107	00166608	U2638597	7/30/2010	$29,867.64
2011	0000068107	00166613	u2652441	7/30/2010	$39,887.91
2011	0000068107	00166615	U2652445	7/30/2010	$266,200.00
2011	0000068107	00166610	U2652446	7/30/2010	$290,714.11
2011	0000068107	00166612	U2652437	7/30/2010	$1,855,893.16
2011	0000068107	00166617	U2652438	8/2/2010	$3,086.05
2011	0000068107	00166605	U2640780	8/2/2010	$11,286.42
2011	0000068107	00166616	U2652439	8/2/2010	$31,500.00
2011	0000068107	00166618	U2652447	8/2/2010	$44,537.02
2011	0000068107	00166621	U2638601	8/3/2010	$44,537.02
2011	0000068107	00166607	U2627933	8/16/2010	$34,499.52
2011	0000068107	00166619	U2640779	8/27/2010	$48,708.03
2011	0000068107	00188817	U2666648	9/14/2010	$2,524.85
2011	0000068107	00188815	U2666646	9/14/2010	$3,086.05
2011	0000068107	00188803	U2666656	9/14/2010	$22,669.66
2011	0000068107	00188816	U2666647	9/14/2010	$31,500.00
2011	0000068107	00185293	U2655564	9/14/2010	$64,808.27
2011	0000068107	00188814	U2666644	9/14/2010	$1,868,707.58
2011	0000068107	00192362	U2666650	9/17/2010	$26,928.00
2011	0000068107	00192361	U2666649	9/17/2010	$99,077.90
2011	0000068107	00198425	U2666652	10/4/2010	$44,537.02
2011	0000068107	00198440	U2682187	10/5/2010	$285.00
2011	0000068107	00198439	U2682182	10/6/2010	$3,086.05
2011	0000068107	00198444	U2682192	10/6/2010	$278,300.00
2011	0000068107	00198443	U2682189	10/8/2010	$50,057.04

FY2011 (Continued)

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2011	0000068107	00198442	U2682188	10/8/2010	$73,178.72
2011	0000068107	00202385	U2669762	10/13/2010	$19,107.59
2011	0000068107	00202389	U2669765	10/13/2010	$316,339.50
2011	0000068107	00202384	U2669766	10/13/2010	$738,781.25
2011	0000068107	00206040	U2682194	10/19/2010	$44,537.02
2011	0000068107	00212911	U2682180	10/27/2010	$1,868,707.58
2011	0000068107	00219780	U2697702	11/10/2010	$1,856.76
2011	0000068107	00219775	U2697701	11/10/2010	$3,086.05
2011	0000068107	00219783	U2697705	11/10/2010	$25,235.76
2011	0000068107	00216425	U2697709	11/10/2010	$32,089.20
2011	0000068107	00216426	U2697712	11/10/2010	$37,811.85
2011	0000068107	00219786	U2697711	11/10/2010	$46,297.06
2011	0000068107	00216423	U2669763	11/10/2010	$52,495.55
2011	0000068107	00216424	U2697707	11/10/2010	$118,166.18
2011	0000068107	00216422	U2640781	11/10/2010	$130,614.23
2011	0000068107	00219784	U2697708	11/10/2010	$184,535.80
2011	0000068107	00219774	U2697700	11/10/2010	$1,868,707.58
2011	0000068107	00219787	U2685385	11/12/2010	$35,063.54
2011	0000068107	00219782	U2697704	11/12/2010	$203,877.63
2011	0000068107	00219788	U2697713	11/17/2010	$44,537.02
2011	0000068107	00219785	U2697710	11/17/2010	$128,882.79
2011	0000068107	00222969	U2712079	11/26/2010	$1,366.56
2011	0000068107	00222968	U2712076	12/1/2010	$3,086.05
2011	0000068107	00222971	U2712083	12/1/2010	$24,916.32
2011	0000068107	00222966	U2700556	12/1/2010	$98,577.97
2011	0000068107	00222965	U2685386	12/1/2010	$110,286.87
2011	0000068107	00222970	U2712082	12/1/2010	$188,987.01
2011	0000068107	00222967	U2712074	12/1/2010	$1,868,707.58
2011	0000068107	00229185	U2712086	12/3/2010	$44,537.02
2011	0000068107	00229184	U2700555	12/22/2010	$28,248.75
2011	0000068107	00229183	U2700554	12/22/2010	$31,536.47
2011	0000068107	00245591	U2726345	1/10/2011	$31,305.12
2011	0000068107	00245590	U2726344	1/10/2011	$65,878.81
2011	0000068107	00245593	U2727094	1/10/2011	$94,553.32
2011	0000068107	00245588	U2726348	1/10/2011	$245,000.00
2011	0000068107	00245583	U2726341	1/10/2011	$1,868,707.58
2011	0000068107	00245586	U2726343	1/11/2011	$1,877.51
2011	0000068107	00245592	U2727093	1/11/2011	$384,881.41

FY2011 (Continued)

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2011	0000068107	00245584	U2726342	1/13/2011	$3,086.05
2011	0000068107	00248816	U2714934	1/13/2011	$23,164.01
2011	0000068107	00248792	U2726350	1/13/2011	$44,537.02
2011	0000068107	00245580	U2714935	1/13/2011	$63,863.10
2011	0000068107	00248793	U2726352	1/13/2011	$295,512.50
2011	0000068107	00248799	U2726356	1/13/2011	$553,840.00
2011	0000068107	00248800	U2726358	1/13/2011	$1,412,359.20
2011	0000068107	00263569	U2739659	2/11/2011	$50,685.82
2011	0000068107	00263576	U2739662	2/11/2011	$71,572.35
2011	0000068107	00263568	U2739658	2/14/2011	$6,242.45
2011	0000068107	00263575	U2739660	2/14/2011	$21,083.04
2011	0000068107	00263581	U2739665	2/16/2011	$23,638.33
2011	0000068107	00263595	U2729910	2/17/2011	$24,503.10
2011	0000068107	00263565	U2739656	2/17/2011	$1,868,707.58
2011	0000068107	00263566	U2739657	2/23/2011	$3,086.05
2011	0000068107	00263577	U2739663	2/23/2011	$44,537.02
2011	0000068107	00272272	U2750831	3/3/2011	$21,160.06
2011	0000068107	00276600	U2751190	3/3/2011	$1,868,707.58
2011	0000068107	00276621	U2751194	3/4/2011	$719.00
2011	0000068107	00276632	U2751196	3/4/2011	$57,398.42
2011	0000068107	00276620	U2751192	3/7/2011	$3,086.05
2011	0000068107	00276640	U2751198	3/8/2011	$29,069.04
2011	0000068107	00276599	U2751203	3/8/2011	$44,537.02
2011	0000068107	00280748	U2751201	3/14/2011	$21,630.00
2011	0000068107	00280747	U2751208	3/14/2011	$23,638.33
2011	0000068107	00280749	U2753214	3/14/2011	$27,125.17
2011	0000068107	00301213	U2685384	4/19/2011	$30,541.06
2011	0000068107	00301215	U2714933	4/19/2011	$31,536.47
2011	0000068107	00301217	U2763802	4/19/2011	$1,477,500.00
2011	0000068107	00304964	U2763795	4/20/2011	$2,105.00
2011	0000068107	00304963	U2763794	4/20/2011	$3,086.05
2011	0000068107	00304969	U2763803	4/20/2011	$8,712.00
2011	0000068107	00304968	U2763801	4/20/2011	$23,638.33
2011	0000068107	00304967	U2763797	4/20/2011	$26,194.08
2011	0000068107	00301210	U2669764	4/20/2011	$35,894.29
2011	0000068107	00301212	U2655563	4/20/2011	$36,720.93
2011	0000068107	00301216	U2763799	4/20/2011	$44,537.02
2011	0000068107	00304965	U2763796	4/20/2011	$57,163.64

FY2011 (Continued)

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2011	0000068107	00301218	U2763793	4/20/2011	$1,868,707.58
2011	0000068107	00320240	6422201	5/20/2011	$3,086.05
2011	0000068107	00320257	6422212	5/20/2011	$23,638.33
2011	0000068107	00320241	6422263	5/20/2011	$27,270.98
2011	0000068107	00320242	6422203	5/20/2011	$38,971.68
2011	0000068107	00320237	6422204	5/20/2011	$44,537.02
2011	0000068107	00320258	6422199	5/20/2011	$70,109.17
2011	0000068107	00320256	6422152	5/20/2011	$1,868,707.58
2011	0000068107	00329917	6424529	6/8/2011	$900.00
2011	0000068107	00329916	6424527	6/9/2011	$3,086.05
2011	0000068107	00329911	6424523	6/9/2011	$19,187.30
2011	0000068107	00329921	6424535	6/9/2011	$23,638.33
2011	0000068107	00329919	6424530	6/9/2011	$34,499.52
2011	0000068107	00329904	6422208	6/9/2011	$50,713.15
2011	0000068107	00329915	6424524	6/9/2011	$54,892.27
2011	0000068107	00329907	U2753215	6/9/2011	$59,910.59
2011	0000068107	00329905	U2729912	6/9/2011	$68,978.27
2011	0000068107	00329906	U2750832	6/9/2011	$73,508.29
2011	0000068107	00329910	6424521	6/9/2011	$1,868,707.58
2011	0000068107	00333223	6420930	6/16/2011	$19,526.47
2011	0000068107	00333234	6423702	6/16/2011	$44,225.07
2011	0000068107	00333236	6424531	6/16/2011	$44,537.02
2011	0000068107	00333284	6422211	6/22/2011	$54,443.10
2011	0000068107	00333288	6424532	6/22/2011	$184,176.52
2011	0000068107	00333285	6422207	6/22/2011	$475,278.48
2011	0000068107	00343778	U2666653	7/6/2011	$45,630.25
2011	0000068107	00343779	U2682195	7/6/2011	$45,630.25
2011	0000068107	00343780	U2697714	7/6/2011	$45,630.25
2011	0000068107	00343781	U2712088	7/6/2011	$45,630.25
2011	0000068107	00343782	U2726354	7/6/2011	$45,630.25
2011	0000068107	00343783	U2739664	7/6/2011	$45,630.25
2011	0000068107	00343789	U2751206	7/6/2011	$45,630.25
2011	0000068107	00343790	U2763800	7/6/2011	$45,630.25
2011	0000068107	00343792	6422210	7/6/2011	$45,630.25
2011	0000068107	00343793	6424533	7/6/2011	$45,630.25
2011	0000068107	00343794	6426910	7/6/2011	$45,630.25
2011	0000068107	00343798	6426915	7/7/2011	$2,195.00
2011	0000068107	00343810	6426912	7/7/2011	$23,638.33

FY2011 (Continued)

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2011	0000068107	00343801	6426905	7/7/2011	$30,666.24
2011	0000068107	00343808	6426901	7/7/2011	$50,239.87
2011	0000068107	00343800	6426907	7/7/2011	$140,934.00
2011	0000068107	00343799	6426908	7/7/2011	$458,360.10
2011	0000068107	00343809	6426900	7/7/2011	$1,868,707.58
2011	0000068107	00333296	6425575	7/8/2011	$37,884.49
2011	0000068107	00343802	6426904	7/11/2011	$3,086.05
2011	0000068107	00343812	6426906	7/11/2011	$44,537.02
2011	0000068107	00343813	U2625188	7/11/2011	$1,003,102.00
2011	0000068107	00333228	6422206	7/13/2011	$443,331.25

FY2011 Total **$36,500,971.79**

FY2012 Payments

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2012	0000068107	00354201	U2652449	8/1/2011	$200,019.92
2012	0000068107	00361930	6429181	8/12/2011	$45,630.25
2012	0000068107	00368744	6429165	8/29/2011	$2,155.00
2012	0000068107	00368742	6429164	8/29/2011	$3,086.05
2012	0000068107	00361932	6429183	8/29/2011	$23,638.33
2012	0000068107	00361933	6429399	8/29/2011	$29,707.90
2012	0000068107	00368740	6428583	8/29/2011	$44,185.69
2012	0000068107	00361929	6429179	8/29/2011	$44,537.02
2012	0000068107	00368741	6429168	8/29/2011	$73,499.54
2012	0000068107	00368743	6429178	8/29/2011	$1,868,707.58
2012	0000068107	00372305	6432133	9/1/2011	$47,925.69
2012	0000068107	00372306	6432119	9/1/2011	$1,919,101.58
2012	0000068107	00372315	6432122	9/2/2011	$3,086.05
2012	0000068107	00372324	6432135	9/2/2011	$24,347.42
2012	0000068107	00372316	6432123	9/2/2011	$35,457.84
2012	0000068107	00372323	6432134	9/2/2011	$46,999.17
2012	0000068107	00372318	6432126	9/2/2011	$176,764.00
2012	0000068107	00372320	6432129	9/2/2011	$255,308.00
2012	0000068107	00372319	6432128	9/6/2011	$2,466.00
2012	0000068107	00372322	6432131	9/13/2011	$6,003.74

FY2012 (Continued)

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2012	0000068107	00392552	6434799	10/12/2011	$1,225.00
2012	0000068107	00392563	6434814	10/12/2011	$1,925.90
2012	0000068107	00392547	6434794	10/12/2011	$3,086.05
2012	0000068107	00392539	6434812	10/12/2011	$24,347.42
2012	0000068107	00392538	6434813	10/12/2011	$31,944.00
2012	0000068107	00392537	6434806	10/12/2011	$47,925.69
2012	0000068107	00392535	6429174	10/12/2011	$78,166.00
2012	0000068107	00392536	6434819	10/12/2011	$242,242.00
2012	0000068107	00392540	6434798	10/12/2011	$1,919,101.58
2012	0000068107	00392574	6428584	10/14/2011	$7,457.20
2012	0000068107	00392577	6432130	10/14/2011	$24,752.79
2012	0000068107	00392561	6434801	10/14/2011	$46,177.23
2012	0000068107	00392571	6434817	10/14/2011	$73,105.04
2012	0000068107	00392570	6434815	10/14/2011	$138,610.00
2012	0000068107	00392551	6434796	10/14/2011	$195,598.04
2012	0000068107	00392625	6434824	10/18/2011	$41,305.68
2012	0000068107	00392627	6434809	10/18/2011	$46,999.17
2012	0000068107	00392626	6431068	10/18/2011	$51,193.93
2012	0000068107	00409555	6437331	11/16/2011	$3,086.05
2012	0000068107	00409556	6437332	11/16/2011	$28,110.72
2012	0000068107	00409550	6437341	11/16/2011	$47,925.69
2012	0000068107	00409553	6437347	11/16/2011	$81,659.36
2012	0000068107	00409551	6437346	11/16/2011	$172,908.45
2012	0000068107	00409554	6437328	11/16/2011	$1,919,101.58
2012	0000068107	00409578	6437336	11/21/2011	$3,527.88
2012	0000068107	00409583	6437344	11/21/2011	$24,347.42
2012	0000068107	00409581	6437342	11/21/2011	$46,999.17
2012	0000068107	00409576	6437334	11/21/2011	$154,279.38
2012	0000068107	00416228	6425576	12/7/2011	$33,566.05
2012	0000068107	00416231	6423700	12/7/2011	$48,456.05
2012	0000068107	00420344	6437339	12/8/2011	$285,379.70
2012	0000068107	00423279	6440022	12/15/2011	$46,999.17
2012	0000068107	00423281	6440019	12/15/2011	$323,036.00
2012	0000068107	00423362	6440018	12/20/2011	$1,963.00
2012	0000068107	00423367	6440012	12/21/2011	$1,919,101.58
2012	0000068107	00423366	6440014	12/23/2011	$3,086.05
2012	0000068107	00423365	6440015	12/23/2011	$21,881.64
2012	0000068107	00426300	6440023	12/23/2011	$24,347.42

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2012	0000068107	00426299	6440021	12/23/2011	$47,925.69
2012	0000068107	00423368	6440024	12/23/2011	$54,753.36
2012	0000068107	00423364	6440016	12/23/2011	$56,996.47
2012	0000068107	00442725	6443288	1/26/2012	$3,086.05
2012	0000068107	00442720	6443310	1/26/2012	$24,347.42
2012	0000068107	00442721	6443308	1/26/2012	$46,999.17
2012	0000068107	00442724	6443286	1/26/2012	$1,919,101.58
2012	0000068107	00442740	6443295	1/27/2012	$3,369.00
2012	0000068107	00442726	6443291	1/27/2012	$26,513.52
2012	0000068107	00442727	6443301	1/27/2012	$47,925.69
2012	0000068107	00442722	6443294	1/27/2012	$59,198.44
2012	0000068107	00442723	6443299	1/27/2012	$138,444.00
2012	0000068107	00442739	6443321	1/27/2012	$605,296.80
2012	0000068107	00442737	6443305	1/27/2012	$1,386,998.55
2012	0000068107	00442738	6443311	1/27/2012	$1,824,046.45
2012	0000068107	00442728	6443303	1/27/2012	$1,924,000.00
2012	0000068107	00451378	6446028	2/8/2012	$24,347.42
2012	0000068107	00447213	6429177	2/8/2012	$347,379.75
2012	0000068107	00451376	6446023	2/9/2012	$1,017.00
2012	0000068107	00451377	6446027	2/10/2012	$46,999.17
2012	0000068107	00451379	6446026	2/10/2012	$47,925.69
2012	0000068107	00451375	6446022	2/10/2012	$56,653.25
2012	0000068107	00451373	6446020	2/17/2012	$3,086.05
2012	0000068107	00451431	6446021	2/17/2012	$14,374.80
2012	0000068107	00472707	6448809	3/16/2012	$47,925.69
2012	0000068107	00472705	6443318	3/16/2012	$59,844.55
2012	0000068107	00472703	6446206	3/16/2012	$63,306.44
2012	0000068107	00472712	6446019	3/16/2012	$1,919,101.58
2012	0000068107	00472714	6448794	3/16/2012	$1,919,101.58
2012	0000068107	00472721	6448799	3/20/2012	$8,508.00
2012	0000068107	00472728	6448819	3/20/2012	$11,360.00
2012	0000068107	00472722	6448801	3/20/2012	$20,124.72
2012	0000068107	00472724	6448808	3/20/2012	$20,328.00
2012	0000068107	00472727	6448818	3/20/2012	$24,347.42
2012	0000068107	00472720	6448798	3/20/2012	$46,870.70
2012	0000068107	00472726	6448816	3/20/2012	$46,999.17
2012	0000068107	00472725	6448813	3/20/2012	$618,000.00
2012	0000068107	00472723	6448807	3/20/2012	$1,936,449.98

FY2012 (Continued)

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2012	0000068107	00476862	6448803	3/29/2012	$116,827.83
2012	0000068107	00476863	6446029	3/29/2012	$316,339.50
2012	0000068107	00476864	6448811	3/29/2012	$316,339.50
2012	0000068107	00481360	6448796	4/5/2012	$3,086.05
2012	0000068107	00485463	6450730	4/10/2012	$1,000.00
2012	0000068107	00485461	6450728	4/12/2012	$3,086.05
2012	0000068107	00485460	6450735	4/12/2012	$3,704.42
2012	0000068107	00485398	6450740	4/12/2012	$11,360.00
2012	0000068107	00485393	6450732	4/12/2012	$12,777.60
2012	0000068107	00485397	6450739	4/12/2012	$24,347.42
2012	0000068107	00485462	6450729	4/12/2012	$45,717.60
2012	0000068107	00485396	6450738	4/12/2012	$46,999.17
2012	0000068107	00485392	6450736	4/12/2012	$47,925.69
2012	0000068107	00485464	6450734	4/12/2012	$109,892.00
2012	0000068107	00485394	6450737	4/12/2012	$206,000.00
2012	0000068107	00485395	6450725	4/12/2012	$1,919,101.58
2012	0000068107	00489157	6454149	4/16/2012	$560.00
2012	0000068107	00489104	6454152	4/16/2012	$47,925.69
2012	0000068107	00489105	6454145	4/16/2012	$1,919,101.58
2012	0000068107	00489153	6454147	4/19/2012	$3,086.05
2012	0000068107	00489165	6454156	4/19/2012	$11,356.33
2012	0000068107	00489163	6454155	4/19/2012	$24,347.42
2012	0000068107	00489158	6454150	4/19/2012	$32,902.32
2012	0000068107	00489154	6454148	4/19/2012	$39,556.76
2012	0000068107	00489161	6454154	4/19/2012	$46,999.17
2012	0000068107	00489159	6454151	4/19/2012	$76,360.00
2012	0000068107	00472713	6446025	4/19/2012	$143,756.00
2012	0000068107	00489160	6454153	4/19/2012	$206,000.00
2012	0000068107	00516841	6457884	6/7/2012	$3,086.05
2012	0000068107	00524330	6457890	6/15/2012	$17,870.00
2012	0000068107	00524338	6457889	6/15/2012	$206,000.00
2012	0000068107	00524325	6458380	6/15/2012	$293,240.73
2012	0000068107	00524327	6458381	6/15/2012	$666,574.07
2012	0000068107	00524345	6457893	6/18/2012	$11,356.37
2012	0000068107	00524342	6457892	6/18/2012	$24,347.42
2012	0000068107	00524341	6457891	6/18/2012	$46,999.17
2012	0000068107	00524331	6455851	6/18/2012	$61,778.20
2012	0000068107	00531296	6461564	6/28/2012	$1,635.00

FY2012 (Continued)

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2012	0000068107	00531126	6457888	6/28/2012	$47,925.69
2012	0000068107	00531127	6457883	6/28/2012	$1,919,101.58
2012	0000068107	00531128	6457886	6/29/2012	$2,210.00
2012	0000068107	00531294	6461561	7/2/2012	$3,086.05
2012	0000068107	00531177	6458548	7/2/2012	$21,630.00
2012	0000068107	00531313	6461571	7/2/2012	$24,347.42
2012	0000068107	00531175	6457887	7/2/2012	$26,639.52
2012	0000068107	00531312	6461570	7/2/2012	$46,999.17
2012	0000068107	00531174	6461568	7/2/2012	$47,925.69
2012	0000068107	00531310	6461567	7/2/2012	$54,448.00
2012	0000068107	00531295	6461563	7/2/2012	$69,849.87
2012	0000068107	00531176	6457894	7/2/2012	$81,675.00
2012	0000068107	00531311	6461569	7/2/2012	$206,000.00
2012	0000068107	00531178	6461560	7/2/2012	$1,919,101.58
2012	0000068107	00531314	6461572	7/3/2012	$11,356.33
2012	0000068107	00520725	6457895	7/12/2012	$37,933.50
2012	0000068107	00524329	6457885	7/12/2012	$70,366.83

FY2012 Total **$40,130,543.97**

FY2013 Payments

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2013	0000068107	00550182	6459013	8/6/2012	$76,585.00
2013	0000068107	00553921	6462016	8/10/2012	$1,015.80
2013	0000068107	00553910	6466031	8/14/2012	$46,999.17
2013	0000068107	00553911	6466019	8/14/2012	$54,624.24
2013	0000068107	00553915	6466021	8/14/2012	$93,654.00
2013	0000068107	00553920	6462014	8/14/2012	$194,398.66
2013	0000068107	00553916	6466030	8/14/2012	$206,000.00
2013	0000068107	00553919	6459014	8/14/2012	$244,760.00
2013	0000068107	00553917	6455850	8/14/2012	$437,449.39
2013	0000068107	00557547	6466022	8/15/2012	$47,925.69
2013	0000068107	00557567	6466017	8/16/2012	$2,763.00
2013	0000068107	00557570	6466010	8/16/2012	$3,086.05
2013	0000068107	00557571	6466105	8/16/2012	$8,632.14

FY2013 (Continued)

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2013	0000068107	00557564	6466037	8/16/2012	$11,356.33
2013	0000068107	00557565	6466033	8/16/2012	$24,347.42
2013	0000068107	00557572	6466099	8/16/2012	$28,633.44
2013	0000068107	00557554	6461566	8/16/2012	$29,388.48
2013	0000068107	00557569	6466015	8/16/2012	$67,760.80
2013	0000068107	00557566	6466024	8/16/2012	$74,097.50
2013	0000068107	00557563	6466045	8/16/2012	$177,937.50
2013	0000068107	00557568	6466005	8/20/2012	$1,919,101.58
2013	0000068107	00574523	6469527	9/18/2012	$1,210.00
2013	0000068107	00574509	6468055	9/21/2012	$3,086.05
2013	0000068107	00574518	6468068	9/21/2012	$11,697.00
2013	0000068107	00574513	6468060	9/21/2012	$23,958.00
2013	0000068107	00574517	6468067	9/21/2012	$25,077.83
2013	0000068107	00574522	6469524	9/21/2012	$46,177.23
2013	0000068107	00574516	6468066	9/21/2012	$48,409.08
2013	0000068107	00574510	6468057	9/21/2012	$79,320.35
2013	0000068107	00574515	6468065	9/21/2012	$212,180.00
2013	0000068107	00574519	6468070	9/21/2012	$252,777.78
2013	0000068107	00574521	6469521	9/21/2012	$401,478.00
2013	0000068107	00572687	6468053	9/21/2012	$1,971,834.33
2013	0000068107	00572677	6469306	9/26/2012	$40,550.00
2013	0000068107	00572678	6468062	9/26/2012	$47,925.69
2013	0000068107	00572675	6468069	9/26/2012	$185,183.18
2013	0000068107	00572676	6468064	9/26/2012	$316,339.50
2013	0000068107	00572674	6469303	9/26/2012	$321,890.00
2013	0000068107	00582742	6469304	10/5/2012	$63,080.00
2013	0000068107	00553918	6457897	10/9/2012	$3,475.88
2013	0000068107	00557548	6457896	10/9/2012	$187,952.18
2013	0000068107	00586293	6471648	10/16/2012	$5,512.00
2013	0000068107	00586294	6471656	10/16/2012	$11,697.00
2013	0000068107	00586295	6471655	10/16/2012	$25,077.83
2013	0000068107	00586312	6471649	10/16/2012	$33,541.20
2013	0000068107	00586297	6471654	10/16/2012	$48,409.08
2013	0000068107	00586300	6471650	10/16/2012	$51,128.00
2013	0000068107	00586313	6471647	10/16/2012	$119,130.32
2013	0000068107	00586298	6471653	10/16/2012	$212,180.00
2013	0000068107	00586316	6471645	10/17/2012	$3,086.05
2013	0000068107	00586317	6471392	10/17/2012	$1,971,834.33

FY2013 (Continued)

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2013	0000068107	00586324	6471652	10/23/2012	$47,937.02
2013	0000068107	00586325	6471651	10/23/2012	$48,550.00
2013	0000068107	00586318	6471657	10/23/2012	$155,102.39
2013	0000068107	00574524	6470718	11/15/2012	$2,157.00
2013	0000068107	00610027	6476362	11/29/2012	$5,420.00
2013	0000068107	00610025	6476313	11/29/2012	$11,697.00
2013	0000068107	00610011	6472990	11/29/2012	$15,830.42
2013	0000068107	00610018	6476298	11/29/2012	$17,194.90
2013	0000068107	00610023	6476307	11/29/2012	$25,077.83
2013	0000068107	00610010	6476367	11/29/2012	$32,582.88
2013	0000068107	00610013	6472411	11/29/2012	$48,983.22
2013	0000068107	00610020	6476287	11/29/2012	$100,587.42
2013	0000068107	00610026	6476383	11/29/2012	$137,502.26
2013	0000068107	00610021	6476306	11/29/2012	$212,180.00
2013	0000068107	00610012	6476300	11/29/2012	$1,971,834.33
2013	0000068107	00610009	6476357	11/30/2012	$3,086.05
2013	0000068107	00610037	6476515	11/30/2012	$47,925.69
2013	0000068107	00610038	6476371	11/30/2012	$48,100.00
2013	0000068107	00610022	6476303	11/30/2012	$48,409.08
2013	0000068107	00610008	6476364	11/30/2012	$156,459.41
2013	0000068107	00610005	6472238	11/30/2012	$865,267.05
2013	0000068107	00614340	6479941	12/5/2012	$1,382.00
2013	0000068107	00614318	6479919	12/7/2012	$8,025.00
2013	0000068107	00614317	6479942	12/7/2012	$25,555.20
2013	0000068107	00614313	6479944	12/7/2012	$33,750.00
2013	0000068107	00614312	6479957	12/7/2012	$170,833.00
2013	0000068107	00614314	6479913	12/7/2012	$949,018.50
2013	0000068107	00614329	6479780	12/7/2012	$1,971,834.33
2013	0000068107	00614337	6479928	12/10/2012	$3,086.05
2013	0000068107	00614335	6479874	12/10/2012	$11,697.00
2013	0000068107	00614341	6479976	12/10/2012	$12,730.41
2013	0000068107	00614334	6479869	12/10/2012	$25,077.83
2013	0000068107	00614333	6479859	12/10/2012	$48,409.08
2013	0000068107	00614332	6479856	12/10/2012	$212,180.00
2013	0000068107	00614331	6479813	12/10/2012	$898,495.37
2013	0000068107	00614315	6479845	12/12/2012	$47,925.69
2013	0000068107	00614342	6479977	12/13/2012	$7,918.34
2013	0000068107	00614339	6479935	12/13/2012	$204,133.30

FY2013 (Continued)

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2013	0000068107	00631215	6483165	1/8/2013	$1,101.00
2013	0000068107	00631205	6483202	1/11/2013	$5,250.00
2013	0000068107	00631206	6483148	1/11/2013	$47,925.69
2013	0000068107	00631208	6479910	1/11/2013	$149,099.52
2013	0000068107	00631209	6476332	1/11/2013	$175,906.73
2013	0000068107	00631207	6482992	1/11/2013	$186,691.36
2013	0000068107	00631231	6483069	1/14/2013	$11,697.00
2013	0000068107	00631224	6483025	1/14/2013	$48,409.08
2013	0000068107	00631221	6483196	1/14/2013	$69,098.12
2013	0000068107	00631230	6483060	1/14/2013	$212,180.00
2013	0000068107	00631223	6482905	1/14/2013	$1,971,834.33
2013	0000068107	00631295	6483040	1/16/2013	$2,675.00
2013	0000068107	00631293	6483153	1/16/2013	$3,086.05
2013	0000068107	00631297	6483053	1/16/2013	$25,077.83
2013	0000068107	00631294	6483203	1/16/2013	$59,364.00
2013	0000068107	00634872	6483170	1/24/2013	$25,555.20
2013	0000068107	00637955	6486558	1/28/2013	$1,070.00
2013	0000068107	00637951	6486551	1/30/2013	$2,675.00
2013	0000068107	00637948	6486547	1/30/2013	$25,077.83
2013	0000068107	00637952	6486552	1/30/2013	$40,734.00
2013	0000068107	00637953	6486554	1/31/2013	$3,086.05
2013	0000068107	00637950	6486549	1/31/2013	$11,697.00
2013	0000068107	00637946	6486546	1/31/2013	$48,409.08
2013	0000068107	00637954	6486556	1/31/2013	$68,371.10
2013	0000068107	00637943	6486543	1/31/2013	$212,180.00
2013	0000068107	00637942	6486478	1/31/2013	$1,971,834.33
2013	0000068107	00637939	6486363	2/4/2013	$47,925.69
2013	0000068107	00646402	6486562	2/12/2013	$23,958.00
2013	0000068107	00664253	6479974	3/5/2013	$918.70
2013	0000068107	00664255	6483210	3/7/2013	$3,085.70
2013	0000068107	00664254	6486575	3/7/2013	$142,370.92
2013	0000068107	00664265	6476371A	3/8/2013	$10,101.00
2013	0000068107	00664264	6479944A	3/8/2013	$7,087.50
2013	0000068107	00664266	6490020	3/8/2013	$114,950.00
2013	0000068107	00664267	6489028	3/8/2013	$47,925.69
2013	0000068107	Pending	6488910	Pending	$1,971,834.33
2013	0000068107	Pending	6488924	Pending	$212,180.00
2013	0000068107	Pending	6488928	Pending	$48,409.08
2013	0000068107	Pending	6488929	Pending	$25,077.83

FY2013 (Continued)

Fiscal Year	Vendor ID	Voucher ID	Invoice	Date	Sum Amount
2013	0000068107	Pending	6488931	Pending	$11,697.00
2013	0000068107	Pending	6488934	Pending	$13,578.00
2013	0000068107	Pending	6488957	Pending	$3,086.05
2013	0000068107	Pending	6488960	Pending	$42,304.23
2013	0000068107	Pending	6488963	Pending	$1,521.00
2013	0000068107	Pending	6488965	Pending	$24,277.44
2013	0000068107	Pending	6489079	Pending	$2,675.00
2013	0000068107	Pending	6490061	Pending	$172,308.00
2013	0000068107	Pending	6490077	Pending	$160,416.67
2013	0000068107	Pending	6490142	Pending	$20,248.26
2013	0000068107	Pending	6490320	Pending	$21,054.00
2013	0000068107	Pending	6491482	Pending	$1,971,834.33
2013	0000068107	Pending	6491413	Pending	$212,180.00
2013	0000068107	Pending	6491456	Pending	$48,409.08
2013	0000068107	Pending	6491457	Pending	$25,077.83
2013	0000068107	Pending	6491459	Pending	$11,697.00
2013	0000068107	Pending	6491460	Pending	$2,675.00
2013	0000068107	Pending	6491463	Pending	$13,578.00
2013	0000068107	Pending	6491483	Pending	$47,925.69
2013	0000068107	Pending	6491642	Pending	$195,453.97

FY2013 Total **$30,147,555.42**

Non-Competitive Amendment Request

NOT required for a contract with a federal, Tennessee, or Tennessee local government entity or a grant.
Route a completed request, as one file in PDF format, via e-mail attachment sent to: Agsprs.Agsprs@state.tn.us

APPROVED
CENTRAL PROCUREMENT OFFICER

Request Tracking #	**31865-00080**
1. Procuring Agency	**Department of Finance and Administration Division of Health Care Finance and Administration Bureau of TennCare**
2. Contractor	**HP Enterprise Services, LLC (formerly Electronic Data Systems, LLC)**
3. Contract #	**FA1028520**
4. Proposed Amendment #	**1**
5. Edison ID #	**12056**

6. Contract Begin Date	**July 1, 2009**
7. Current Contract End Date *– with ALL options to extend exercised*	**June 30, 2013**
8. Proposed Contract End Date *– with ALL options to extend exercised*	**June 30, 2015**
9. Current Maximum Contract Cost *– with ALL options to extend exercised*	**$170,662,054.00**
10. Proposed Maximum Contract Cost *– with ALL options to extend exercised*	**$ 258,814,054.00**
11. Office for Information Resources Endorsement *– information technology service (N/A to THDA)*	☐ **Not Applicable** x **Attached**
12. eHealth Initiative Support *– health-related professional, pharmaceutical, laboratory, or imaging*	☐ **Not Applicable** ☐ **Attached**
13. Human Resources Support *– state employee training service*	☐ **Not Applicable** ☐ **Attached**

14. Explanation Need for the Proposed Amendment

This contract is for the operation and enhancement of the TennCare Management Information Systems. This amendment is needed to continue the systems management for TennCare and provide funding to: (1) Continue on-going system maintenance, modification and operations through June 2015; (2) Clean-up to bring the language current (e.g., generic third party references instead of named systems or

Request Tracking #	31865-00080

entities; updates to inputs, process or outputs); (3) Continue postal services for notices through June 2015 and (4) Continue hardware, software, maintenance through June 2015.

New or continued enhancements and projects include: (1) Service Oriented Architecture infrastructure, in support of Modularity (1 of the 7 new CMS Standards and Conditions for enhanced Federal Financial Participation); (2) Enterprise Provider Portal framework to promote provider self-service and strengthen the framework for provider access security management; (3) Extension of ICD-10 deployment project based on revised CMS schedule, and (4) Supplemental support for extensive system changes related to federal mandates.

15. Name & Address of the Contractor's Principal Owner(s)
– NOT required for a TN state education institution

Corporate CEO:

Meg Whitman

Hewlett-Packard Company

3000 Hanover Street

Palo Alto, CA 94304-1185

16. Evidence Contractor's Experience & Length Of Experience Providing the Service

As a subsidiary of Hewlett-Packard, operating as part of the HP Enterprise Business segment, HP Enterprise Services (formerly Electronic Data Systems) has supported healthcare programs for more than 42 years, since the inception of both Medicare and Medicaid in 1965, with advanced claims processing systems and information management services. HP runs Medicaid data systems for 21 states, processing millions of claims from hospitals and doctors, enrolling providers, verifying patients' eligibility and authorizing some services. In addition, HP provides services to Medicare programs, major pharmaceutical companies, other federal healthcare programs, insurance carriers, health maintenance organizations (HMOs), and employer corporations. HP has been a valuable contracted partner with TennCare in the State's effort to manage health care to approximately 1.2 million enrollees.

17. Efforts to Identify Reasonable, Competitive, Procurement Alternatives

TennCare released a Request for Proposal to identify a contractor for the operation and enhancement of the TennCare Management Information System. The winning proposer with highest combined technical and cost scores and the subsequent contractor, was ACS State Healthcare (HP was second). However, due to mutual agreement between ACS and TennCare, the contract was terminated and TennCare contracted with Electronic Data Systems, (current name changed to Hewlett-Packard). HP was the incumbent contractor and had been providing, through a competitively bid contract, the operation of the TennCare Management Information System for several years. The current contract that is being amended was awarded as non competitive based on expertise and experience with TennCare MMIS and the fact that they were the second highest proposer.

18. Justification *– specifically explain why non-competitive negotiation is in the best interest of the state*

This contract with HP Enterprise Services for the operation and management enhancement of the TennCare Management Information Systems is being amended to continue system management as well as provide new enhancements and projects, and provide funding to support the term extension of the contract. These projects include Service Oriented Architecture infrastructure, in support of Modularity (1 of the 7 new CMS Standards and Conditions for enhanced Federal Financial Participation); Enterprise Provider Portal framework to promote provider self-service and strengthen the framework for provider access security management; Extension of ICD-10 deployment project based on revised CMS schedule, and Supplemental support for extensive system changes related to federal mandates. The Bureau of TennCare respectfully requests approval of this amendment request.

Request Tracking #	31865-00080

Agency Head Signature and Date – *MUST be signed by the ACTUAL agency head as detailed on the current Signature Certification. Signature by an authorized signatory is acceptable only in documented exigent circumstances*

Mark C. Smith 3/13/13

CD

OIR Pre-Approval Endorsement Request
E-Mail Transmittal

TO : Jane Chittenden, OIR Procurement & Contract Management Director
Department of Finance & Administration
E-mail : Jane.Chittenden@tn.gov

FROM : Alma Chilton
E-mail : alma.chilton@tn.gov

DATE : March 8, 2013

RE : Request for OIR Pre-Approval Endorsement

Applicable RFS #	**31865-00080**
OIR Endorsement Signature & Date:	
Mark Bruzel (gc)	3/28/13
Chief Information Officer	

NOTE: Proposed contract/grant support is applicable to the subject IT service technical merit.

Office for Information Resources (OIR) pre-approval endorsement appears to be required pursuant to professional service contracting regulations pertaining to procurements with information technology as a component of the scope of service. This request seeks to ensure that OIR is aware of and has an opportunity to review the procurement detailed below and in the attached documents.

Please document OIR endorsement of the described procurement (with the appropriate signature above), and return this document via e-mail at your earliest convenience.

Contracting Agency	**Department of Finance and Administration** **Division of Health Care Finance and Administration** **Bureau of TennCare**
Agency Contact (name, phone, e-mail)	**Alma Chilton**

Subject Procurement Document (mark one)

- ☐ **RFP**
- ☐ Competitive Negotiation Request
- ☐ Alternative Procurement Method Request
- ☐ Non-Competitive Contract Request
- X Non-Competitive Amendment Request
- ☐ Contract
- ☐ Contract Amendment
- ☐ Grant
- ☐ Grant Amendment

Applicable RFS # 31865-00080

Information Systems Plan (ISP) Project Applicability

~~BC67E81~~ DCST-2007-LP-001

Response Confirmed by IT Director/Staff (name): Max Arnold

Required Attachments (as applicable – copies without signatures acceptable)

- ☐ RFP, Competitive Negotiation Request, Alternative Procurement Method Request, Non-Competitive Contract Request, Non-Competitive Amendment Request
- **x** Original Contract/Grant or Amendment
- **x** Proposed Contract/Grant or Amendment

Subject Information Technology Service Description

(Brief summary of information technology services involved. Clearly identify included technologies such as system development/maintenance, security, networking, *etc.* As applicable, identify the contract & solicitation sections related to the IT services.)

This contract is for the operation and enhancement of the TennCare Management Information Systems. This amendment is needed to continue the systems management for TennCare and provide funding to: (1) Continue on-going system maintenance, modification and operations through June 2015; (2) Clean-up to bring the language current (e.g., generic third party references instead of named systems or entities; updates to inputs, process or outputs); (3) Continue postal services for notices through June 2015 and (4) Continue hardware, software, maintenance through June 2015.

New or continued enhancements and projects include: (1) Service Oriented Architecture infrastructure, in support of Modularity (1 of the 7 new CMS Standards and Conditions for enhanced Federal Financial Participation); (2) Enterprise Provider Portal framework to promote provider self-service and strengthen the framework for provider access security management; (3) Extension of ICD-10 deployment project based on revised CMS schedule, and (4) Supplemental support for extensive system changes related to federal mandates.

cy13-1953

Rule Exception Request

Route completed request, as one file in PDF format, via e-mail attachment sent to: Agsprs.Agsprs@state.tn.us

APPROVED

Jessica Robertson

CENTRAL PROCUREMENT OFFICER

Request Tracking #	31865-00080
1. Contract #	FA1028520
2. Service Caption	Operation and Enhancement of the TennCare Management Information Systems
3. Contractor	HP Enterprise Systems, LLC (formerly Electronic Data Systems, LLC)
4. Contract Period *(with ALL options to extend exercised)*	96 months (July 1, 2009 – June 30, 2015 with option to extend two additional years)
5. Contract Maximum Liability *(with ALL options to extend exercised)*	$258,814,054.00 (through June 30, 2015)

6. Rule *(for which the exception is requested)*

- [ ] 0620-3-3-.03(2)(a) OR 0620-3-3-.05 requiring compliance with relevant model guidelines (only if required by oversight authorities)
- [ ] 0620-3-3-.05(5) requiring the prescribed Nondiscrimination contract provision
- [x] 0620-3-3-.07(5) prohibiting a contract term greater than five (5) years
- [ ] 0620-3-3-.07(8) prohibiting a contract with a former state employee in within six (6) months of termination
- [ ] 0620-3-3-.07(22) requiring contractor travel reimbursement in accordance with state travel regulations
- [ ] OTHER *(cite the relevant rule below)*

7. Explanation of Rule Exception Requested

The Bureau of TennCare is requesting exception to the rule prohibiting a contract term greater than five (5) years.

Request Tracking #	31865-00080
8. Justification	The Bureau of TennCare is requesting a two (2) year term extension to the current HP Enterprise Systems, LLC contract with an additional two (2) one (1) year term extension options available. The continuation of this contract for the provision of the Operation, Modifications and Enhancement of the TennCare Management Information System will allow the Bureau to concentrate its resources on the implementation of the TennCare Eligibility Determination System (TEDS). This project has a very aggressive time frame and is mandated to be functional no later than Jan 1, 2014 under the Affordable Care Act. In addition to meeting the Affordable Care Act mandate, this term extension of the existing contract will provide the Bureau of TennCare the ability to research and document the strategic direction for the TennCare Management Information System. This direction will encompass the service oriented architecture infrastructure, in support of Modularity (1 of 7 new CMS standards and conditions for enhanced federal financial participation); provision of an Enterprise Provider Portal framework to promote provider self-service and strengthen the framework for provider access security management; extension of ICD-10 deployment project based on revised CMS schedule, and supplemental support. For these reasons, the Bureau of TennCare requests approval of the term extension exceeding five (5) years to the existing HP contract, ensuring continuation and completion of extensive system changes related to federal mandates, some of which began implementation under the current contract with completion expected to be accomplished during the planned extension.

Agency Head Signature and Date *(contracting agency head or authorized signatory)*

Mark A. Emkes/CD

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

HP Enterprise Services, LLC
5400 LEGACY DRIVE
PLANO, TX 75024 USA

January 6, 2010

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

Control # : 587394 Status: Active
Filing Type: Limited Liability Company - Foreign

Document Receipt

Receipt # : 37525	Filing Fee:	$20.00
Payment-Check/MO - CFS, Nashville, TN		$20.00

Amendment Type: Articles of Amendment Image # : 6640-0339
Filed Date: 01/06/2010 1:19 PM

This will acknowledge the filing of the attached articles of amendment with an effective date as indicated above. When corresponding with this office or submitting documents for filing, please refer to the control number given above.

Tre Hargett, Secretary of State
Business Services Division

Field Name	Changed From	Changed To
Filing Name	ELECTRONIC DATA SYSTEMS, LLC	HP Enterprise Services, LLC

32

State of Tennessee

Department of State
Corporate Filings
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR AMENDED CERTIFICATE OF AUTHORITY (LIMITED LIABILITY COMPANY)

RECEIVED STATE OF TENNESSEE 2010 JAN -6 PM 1:19 TRE HARGETT SECRETARY OF STATE

FILED

For Office Use Only

0548-0339

To the Secretary of State of the State of Tennessee:

Pursuant to the provisions of §48-246-303 of the Tennessee Limited Liability Company Act or §48-249-906 of the Tennessee Revised Limited Liability Company Act, the undersigned hereby applies for an amended certificate of authority to transact business in the State of Tennessee, and for that purpose sets forth:

1. The currently recorded name of the Limited Liability Company is: Electronic Data Systems, LLC

   If different, the name under which the amended certificate of authority is to be obtained is: HP Enterprise Services, LLC

2. The state or country under whose law it is organized is: Delaware

   and its date of formation is: 08/29/2008 (must be month, day and year).

3. The complete street address (including zip code) of its principal office is:

   5400 Legacy Drive, Plano, TX 75024
   Street City State/Country Zip Code

4. The complete street address (including the county and the zip code) of its registered office in Tennessee is:

   800 S. Gay Street, Suite 2021, Knoxville, Tennessee, Knox County 37929
   Street City/State County Zip Code

   The name of its registered agent at that office is: C T CORPORATION SYSTEM

5. If the provisions of TCA §48-249-309(i) (relating to foreign series LLCs) apply, then the information required by that section should be attached as part of this document.

6. Please insert the number of members at the date of filing if more that six (6). _____

NOTE: This application must be accompanied by a certificate of existence or a document of similar import (for example, a certificate of good standing) duly authenticated by the Secretary of State or other official having custody of Limited Liability Company records in the state or country under whose law it is formed. The certificate shall not bear a date of more than two (2) month prior to the date the application is successfully filed in Tennessee.

12/18/09
Signature Date

Electronic Data Systems, LLC
Name of Limited Liability Company

Manager
Signer's Capacity

Signature

Lester D. Ezrati
Name (typed or printed)

SS-4231 (Rev. 01/06) Filing Fee:$20 RDA 2458

Delaware

The First State

RECEIVED
STATE OF TENNESSEE
2010 JAN -6 PM 1:19
TRE HARGETT
SECRETARY OF STATE

0940.0340

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "HP ENTERPRISE SERVICES, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE FIFTH DAY OF JANUARY, A.D. 2010.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN PAID TO DATE.

Jeffrey W. Bullock, Secretary of State

2387022 8300

AUTHENTICATION: 7738753

100010070

DATE: 01-05-10

You may verify this certificate online at corp.delaware.gov/authver.shtml

CONTRACT AMENDMENT

Agency Tracking #	Edison ID	Contract #	Amendment #
31865-00080	12056	FA1028520	01

Contractor Legal Entity Name	Edison Vendor ID
HP Enterprise Services, LLC (formerly Electronic Data Systems, LLC)	68107

Amendment Purpose & Effect(s)

Extends Term, Increases Maximum Liability, Updates Scope

Amendment Changes Contract End Date: ☒ YES ☐ NO **End Date:** June 30, 2015

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): **$ 88,152,000.00**

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2010	$11,482,397.00	$38,569,908.00			$50,052,305.00
2011	$10,984,187.00	$31,312,155.00			$42,296,342.00
2012	$9,009,881.00	$29,611,737.00			$38,621,618.00
2013	$9,278,199.00	$30,413,590.00			$39,691,789.00
2014	$9,020,081.00	$35,274,740.00			$44,294,821.00
2015	$9,147,467.00	$34,709,712.00			$43,857,179.00
TOTAL:	**$58,922,212.00**	**$199,891,842.00**			**$258,814,054.00**

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

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

Speed Chart (optional) See Attached

Account Code (optional)

OCR USE

AMENDMENT #1
CONTRACT FA1028520
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AND
HP ENTERPRISE SERVICES, L.L.C.

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

1. The following is added as Contract section E.35:

   E.35 Contractor Name

   All references to "Electronic Data Systems, L.L.C." or "EDS" shall be deleted and replaced with "HP Enterprise Services, L.L.C." or "HP."

2. Contract section A.1.1 and all of its subsections is deleted in its entirety and replaced with the following:

A.1.1 Information Technology Methodology (ITM)

The Contractor shall utilize the State's Information Technology Methodology (ITM) in the transition, development and implementation of the TCMIS Start-up, Operations and Enhancements. The Project Management Processes are pertaining to organizing and controlling the work of the project. The Product Development Phases involve the construction of the product enhancements for the project. The Project Management Processes encompass the takeover and the development of enhancements. Throughout the project, the Contractor shall produce numerous Project Management Process and Product Development Phase deliverables. Some of these products are specific deliverables that shall be managed, produced, and updated by the Contractor. Others are natural work-products arising out of the shared effort of both parties. TennCare shall prepare and issue Control Memorandum(a) that shall contain the history, background, and any other pertinent information relative to the deliverable, report or matter(s) being addressed. The Control Memorandum(a) shall detail the action to be taken by the Contractor.

Except for matters which require a Contract amendment as described in Section D.2, all services to be provided under this Contract shall be managed by, and all matters relating to this Contract shall be documented and resolved using the project management principles and contract management processes set forth in this Section A.1.

The processes and phases are as follows:

A.1.1.1 Project Management Processes

The term "Project Management" shall mean the general project management best practices and principles embodied in the Project Management Body of Knowledge (PMBOK) published by the Project Management Institute (PMI) that are applied by the State and Contractor to manage all services provided under the Contract. Project Management principles include, but are not limited to, the Information Technology Methodology (ITM) and the following processes:

a) Planning – Devise and maintain the "Project Plan" using input from the initiation of the project proposal to accomplish the business need.

b) Execution – Carry out the activities included in the "Project Plan" that includes developing the project team, coordinating activities, distributing information and verifying work results.
c) Controlling – Ensure project's objectives are met by monitoring and measuring its progress.
d) Quality Management – Identify quality policies, objectives, and responsibilities to be used for the project, and ensure that these are implemented and monitored throughout the term of the project.
e) Procurement Management – Acquire goods and services from vendors, contractors, and/or suppliers, and to manage the contracts that are established through contract completion.
f) Phase/Project Closure – Evaluate the aspects of the project's status, make go/no go decisions and obtains final project sign off.

A.1.1.2 Product Development Phases

a) Scope and Feasibility – Establish the high-level requirement and assess impacts, constraints and recommendations for the product to be developed.
b) Requirement Definition and Solution Evaluation – Establish detailed requirements and evaluate high-level solution alternatives for satisfying requirements.
c) Design – Design the product to a detailed level and provide the framework for constructing the product.
d) Construction – Build and test product components, integrate and test component assemblies, and prepare for acceptance testing.
e) Acceptance Test – Evaluate the ability of the product to satisfy all product requirements by the customer organization and obtain necessary signoff on the product.
f) Implementation – Complete product integration, train users, monitor product operation and update documentation as needed.

A.1.1.3 Contract Management Processes

The term "Contract Management" shall mean the use of the Control Memorandum Process (CMP) and the Contract Change Order Process to manage matters arising under the Contract that do not require a Contract amendment as described in Sections A.1.2.4 and A.1.2.3 respectfully. The CMP can be used to manage a wide variety of Contract matters, including, but not limited to, clarification or enforcement of Contract requirements, to issue or request instruction to document submission of Contract deliverables, or to document required action, approval or disposition.

3. Contract section A.1.2 and all of its subsections are deleted in its entirety and replaced with the following:

A.1.2 Project Management and Approach

The approach the parties have agreed to use relating to Project Management includes, but is not limited to, the processes and tools described in the following sections:

a) Enhancements and Assessments, as provided in Contract Section A.2;
b) Work Requests (WR) for Maintenance matters, as provided in Contract Section A.4.1;
c) System Change Request (SCR) for Modification matters, as provided in Contract Section A.4.2; and
d) Special Projects, as provided in Contract Section A.4.3.

A.1.2.1 State's Information Technology Methodology (ITM)

The Contractor shall utilize the State's ITM in the development of its approach to the TCMIS Project. Since the State's ITM is defined at a high-level for use on all types and sizes of information technology (IT) projects, the Contractor shall develop a detailed project management methodology within the guidelines of the State's ITM.

A.1.2.2 Access to the State's ITM

The State's ITM includes process definitions, guidelines, document deliverable templates, and tools that support two (2) basic categories of processes: (a) Project Management Processes, and (b) Product Development Methodology.

The Project Management Processes category describes the procedures for organizing and controlling the work of the project, which shall extend over one (1) or more Product Development Phases. The Product Development Phases describe the processes for developing the enhancements.

A.1.2.3 Contract Change Order Process

A.1.2.3.1 In this Section, the State's Contract Change Order Process is described for Contractor requirements and deliverables specific to the Bureau's needs and to comply with changes in State and Federal laws, regulations, and court orders that impact TennCare business processes.

Modified functionalities defined in this Contract shall be managed using the Contract Change Order Process. As required, monitoring of the new functions shall be accomplished by the creation of new reports and performance monitoring tools developed through the Contract Change Order Process.

A.1.2.3.2 The Change Order management principles are as follows:

a) The scope and any changes resulting in a Contract Change Order, shall be reviewed with and approved by the appropriate Bureau leadership, in accordance with the Bureau's published Contractor Change Order approval procedures.

b) All parties shall maintain commitment and adherence to the scope.

c) All Contract Change Orders shall be documented and submitted to the Bureau assigned Project Director who shall be a Bureau employee or designee and who shall be responsible for oversight of the Contract Change Order process as outlined in this section.

A.1.2.3.3 Contract Change Order Approach

Proposed Contract Change Orders shall be reviewed, prioritized, assigned, and resolved through the CMP when requested by the State. A Contract Change Order may be required when there is an impact on resources, timeline, and/or budget that shall require approval. Therefore, a justification for the Contract Change Order shall be documented, including development of a cost analysis. Changes that affect the business processes/system functionality or technical architecture and/or occur after the deliverable/product has been accepted shall be researched to determine the impact on the project. Frequently, these particular matters shall require a Contract Change Order.

A.1.2.3.4 Contract Change Order Procedure

Following is a description of each step in the Contract Change Order procedure:

a) Create and Log Change Order – The process shall be initiated by a matter being deemed a Contract Change Order and submitted through the CMP. The Contract Change Order request shall specify the nature of the change and the business justification for the change (the justification may be preliminary and a further evaluation shall be performed as part of the process).

b) Assign Ownership – Each Contract Change Order request shall be assigned an owner by the Project Director (or his/her designee) who shall be responsible for performing an evaluation of the impact of the change on the project's budget.

c) Perform Impact Analysis – Each Contract Change Order request shall be analyzed to determine its potential impact on the budget, resources and schedule within an agreed timeline. Costs, benefits, impact on quality, staffing and risk, and the associated timing of each shall be evaluated and an analysis shall be prepared for presentation to the Steering Committee. The

impact analysis including all required information shall be documented in a Control Memorandum if requested by the State.

d) Obtain Approvals – The Cost/Benefit evaluation that shall be performed during the "Perform Impact Analysis" step in this process shall be presented to the Steering Committee who shall approve or reject the requested change. At the State's option, the approval or rejection of the requested change shall be documented in a Control Memorandum containing a Control Directive that is prepared by the State and sent to the Contractor.

e) Update Documentation – If the Contract Change Order request is accepted and/or approved, project management shall move forward with implementing the change. All necessary documentation shall be updated accordingly (e.g., project plan, risk assessment, and in a Control Memorandum, if applicable).

A.1.2.3.5 Contract Change Order Escalation

A Contract Change Order request that cannot be resolved shall be treated the same as any other unresolved matter as follows:

The State's Project Director (or his/her designee) shall review the analysis of the requested Contract Change Order and provide notice of determination through a Control Memorandum as set forth in Section A.1.2.4. If the Contractor disagrees with the State's determination, the Contractor may request, through a Control Memorandum to the State, escalation of the requested Contract Change Order to the TennCare Director (or his/her designee) for reconsideration and final determination. Contractor shall send such escalation notice within ten (10) business days of receipt of the State's determination of approval or rejection of the requested Contract Change Order. Notice of the final determination made by the TennCare Director (or his/her designee) will be provided to the Contractor by the Project Director (or his/her designee) through a Control Memorandum. The Parties agree that the appeal steps set forth in the Control Memorandum Process in Section A.1 are the sole method of appeal for Contract Change Order matters, and no further appeal or claim may be filed under the process stated in the second paragraph of Section E.11.

A.1.2.4 Contract Management through Control Memorandum Process (CMP)

The Control Memorandum Process (CMP) is a key component of the Contract Management approach. The CMP shall be utilized by TennCare and Contractor to clarify or enforce Contract requirements, to issue instruction to the Contractor or request instruction from the State, to document submission of Contract deliverables, to document required action, approval or disposition, including, but not limited to, changes in Contractor staffing requirements and disputes or appeals regarding actual or liquidated damages assessments by the State. This process is intended to be a mechanism that allows for the orderly investigation, escalation, and resolution of all matters or questions occurring during the term of the Contract. This process is not intended to replace the standard change management process to accommodate modifications or to bypass processes for mutual agreement in negotiating changes in Contract scope and reimbursement.

A.1.2.4.1 The CMP shall be used to document the following:

a) Contract Change Orders, when requested by the State;
b) All proposed assessments of actual damages and Liquidated Damages;
c) All Special Projects authorized under Section A.6.5 or Section C.3.4 of the Contract; and
d) Such other Contract matters as the State or Contractor may determine.

A.1.2.4.2 Each party shall designate the individual(s) authorized to initiate Control Memoranda. All Control Memoranda submitted to or by the State shall be reviewed and prioritized by the State's Project Director (or his/her designee). All Control Memoranda submitted to the Contractor shall be signed and approved by the State's Project Director (or his/her designee). All Control Memoranda submitted by the Contractor shall be signed and approved by the Contractor's authorized representative.

A.1.2.4.3 Each Control Memorandum issued by either the State or Contractor shall be in writing and contain a unique identification number. All Control Memoranda shall contain the history, background, and any other pertinent information regarding the issue(s) matters being addressed in the Control Memoranda.

A.1.2.4.4 The Contractor shall comply with all Control Memoranda, except where the Control Memorandum is not within the Scope of the Contract. In the event that the Contractor determines that the Control Memorandum is not within the Scope of the Contract, the State and the Contractor shall address the change to the Scope of the Contract through the Contract Change Order Process as described in Section A.1.2.3. Contractor's failure to complete or comply with Control Memoranda as required may result in sanctions including liquidated damages listed in Attachment B (Liquidated Damages) and possible termination of the Contract.

A.1.2.4.5 The various components of the Control Memorandum Process are described below. When issued by the State, the Control Memorandum may include one (1) or more of the following six (6) notices or instructions, as applicable, and shall designate a reasonable due date for Contractor's reply or other action. When the Control Memorandum pertains to actual damages or liquidated damages, the State may issue consecutive Control Memoranda incorporating the applicable notices or instructions as described below.

a. On Request Report (ORR) – a request included in the Control Memorandum issued by TennCare directing the Contractor to provide information by close of business on a designated due date. An ORR shall be treated as a request for information only, and shall not be used to direct that a given task be completed. Failure to complete or comply with an ORR by the due date may result in the assessment of actual damages, if permitted under this Contract, and/or the assessment of liquidated damages listed in Attachment B (Liquidated Damages).

b. Control Directive – an instruction included in the Control Memorandum issued by TennCare that requires the Contractor to complete a certain deliverable or perform any other request from TennCare within the scope of the Contract, by a reasonable designated due date. If the parties are not in agreement that the subject matter of the Control Directive is within the scope of the Contract, the matter shall be escalated through the same process as set forth above in Section A.1.2.3.5 for Contract Change Order Escalation. Once a Control Directive has been issued with the Control Memorandum, it shall be considered to be incorporated into this Contract. Contractor's failure to complete or comply with the Control Directive by the due date may result in the assessment of actual damages, if permitted under this Contract, and/or the assessment of liquidated damages listed in Attachment B (Liquidated Damages) for each day the Control Directive is not completed or complied with as required. Control Directives can only be issued by the State.

c. Potential Actual Damages or Potential Liquidated Damages Notice (PADN/PLDN) – a notice included in the Control Memorandum issued by TennCare to the Contractor that the State has determined that a potential contract performance or compliance issue exists and that the State is contemplating assessing actual damages and/or liquidated damages listed in Attachment B (Liquidated Damages). The State shall notify the Contractor of any potential contract performance or compliance issue within ninety (90) days of the Contractor's written notice of the issue to the State through a Control Memorandum or the State's discovery of the issue. The PADN/PLDN shall identify the Contract provision(s) on which the State bases any potential contract performance or compliance issue and, if available, a projection of the potential actual damages and/or liquidated damages. The parties acknowledge that the total amount of actual damages and/or liquidated damages specified in the PADN/PLDN may not be the final amount assessed. Contractor may, in an attempt to settle this matter informally, within ten (10) business days of receipt of the PADN/PLDN, elect to respond to the PADN/PLDN through the Control Memorandum process. If the State, after review of any information provided by Contractor, continues to assert that potential damages are warranted, the State shall so notify the Contractor through a Control Memorandum. The

timely issuance of a PADN/PLDN satisfies the State's requirement to provide notice of potential damages and preserves the State's rights under the Contract to assess damages. This is the first step in the assessment of actual or liquidated damages.

d. Calculation of Potential Actual Damages or Potential Liquidated Damages Notice (CPADN/CPLDN) – a notice included in the Control Memorandum issued by TennCare to Contractor that calculates the amount of potential actual damages or potential liquidated damages. If the Contractor elects to formally appeal either the basis for or calculation of potential actual or potential liquidated damages, the Contractor must file an appeal by written response to the Control Memorandum within ten (10) business days of receipt of the State's CPADN/CPLDN. The State's Project Director (or his/her designee) shall review the appeal and provide notice of determination through a Control Memorandum. If the Contractor disagrees with the State's initial appeal determination or the Project Director (or his/her designee) is unable to resolve the appeal, the Contractor may request, through a Control Memorandum to the State, escalation of the appeal to the TennCare Director (or his/her designee) for reconsideration and final determination. Contractor shall send such notice within ten (10) business days of receipt of the State's initial appeal determination. Notice of the final determination made by the TennCare Director (or his/her designee) will be provided to the Contractor by the Project Director (or his/her designee) through a Control Memorandum. If the Contractor loses this formal appeal, the State in its sole discretion, may assess actual or liquidated damages. This is the second step in the assessment of actual or liquidated damages. The State may not issue a CPADN/CPLDN before also issuing a PADN/PLDN.

e. Intent to Assess Final Actual Damages/Liquidated Damages Notice (IADN/IALDN) – a notice included in the Control Memorandum issued by TennCare to Contractor that the State is assessing actual damages and/or liquidated damages. This notice shall identify the Contract provision(s) on which the State bases the damages and specify the total amount of actual damages and/or liquidated damages the State intends to assess. At this point, the State may elect to withhold damages from payments due to Contractor. This is the third step in the assessment of actual or liquidated damages. The State may not issue an IADN/IALDN without first issuing a CPADN/CPLDN.

f. Assessment of Actual Damages/Liquidated Damages Notice (AADN/ALDN) – a notice included in the Control Memorandum issued by TennCare containing a final demand for payment of actual and/or liquidated damages. This is the fourth step in the assessment of actual or liquidated damages. The State may not issue an AADN/ALDN before also issuing an IADN/IALDN.

4. The following is added as Contract section A.1.5:

A.1.5 Contractor Coordination with Division of Health Care Finance and Administration (HCFA) entities and State contractors

Contractor shall, as directed by the State, coordinate with, and facilitate the prompt exchange of information between, and work collaboratively with any and all other State contractors performing various TennCare or HCFA services so that the components of the State's TennCare and HCFA programs and services work together seamlessly without delay or interruption. This coordination with other TennCare business partners and HCFA entities' contractors is a requirement of this Scope of Services and Contract. Other than as permitted in Section C of this Contract, Payment Terms and Conditions, Contractor shall not invoice the State for any such coordination services, and the State shall not be liable to the Contractor for payment of any such coordination services, without the prior written consent of the State.

5. Contract section A.2.2.4 is deleted in its entirety and replaced with the following:

A.2.2.4 Enhancement Implementation Timeline

Enhancements may begin immediately after the Contract start date, but no later than three (3) months after the Contract start date. The Contractor shall be required to derive, and submit for approval by the Bureau, a schedule, Staff Plan and Work Plan for each enhancement, including all activities leading to the successful completion of deliverables and milestones for each enhancement, and for compliance with Bureau designated implementation dates.
Following are the requested Enhancements and the timeline for each based on the July 1, 2009 Contract start date:

Enhancement #1 – Capability Maturity Model Integration (CMMI) – This Enhancement requires the Contractor to lead the effort in raising the TennCare capability maturity level to Level Two within twenty-four (24) months of the Contract start date and to Level Three within twenty-four (24) months of being appraised at Level Two. The Contractor shall assess the current level, then plan, schedule, and implement the improvements necessary to reach CMMI Level Two. Appraisal of CMMI level shall be arranged by the Contractor and carried out by an independent third party. Once apprised of having reached CMMI Level Two, the Contractor shall begin the process of reaching CMMI Level Three.
Enhancement #2 – Technology Modernization – This Enhancement requires the Facilities Manager to support the Bureau's upgrade of specific hardware and software suites approaching end of life. The Contractor shall complete all technology modernization initiatives by June 30, 2010.
Enhancement #3 – Project Management Office (PMO) – This Enhancement requires the Contractor to create a PMO for coordinating the multiple aspects and projects within the TCMIS, and to follow the Project Management Body of Knowledge (PMBOK) guidelines for all changes, modifications, projects and enhancements. The creation of a PMO shall begin within two (2) months of the Contract start date, and shall be completed and fully operational by December 31, 2009.
Enhancement #4 – Commercial Off The Shelf (COTS) Dashboard – This Enhancement is to establish the use of a COTS dashboard software product (such as Crystal Xcelsius), that shall be used to report performance metrics and operations indicators. The Contractor shall complete testing, obtain Bureau approval, and implement this Dashboard software by June 30, 2010.
Enhancement #5 – COTS Documentation Software – The Contractor shall secure and operate COTS documentation software with enhanced content management features and enhance Filenet, to be an enterprise-wide content management solution. This Enhancement to facilitate Systems Documentation shall be fully tested, Bureau approved, and implemented by June 30, 2010.
Enhancement #6 – Enhanced Testing Environment – The Contractor shall develop multiple integrated test environments with subsequent promotion to a full system test environment and finally promoted to a regression test environment prior to a production release. This shall require four (4) new test environments. The Contractor shall convert model office to the full systems test environment and the User Acceptance Test environment shall be converted to the regression test environment. This shall be implemented and fully operational by April 28, 2010.
Enhancement #7 – Business Process Improvement – This Enhancement requires the Contractor to develop a complete and detailed business process model of the Bureau and Contractor business processes, and that this process modeling shall include Activity Based Costing. The Contractor shall complete all process documentation by May 2, 2011.
Enhancement #8 – Long-Term Care CHOICES - This Enhancement requires the Contractor to support the Bureau's implementation of the Long-Term Care (LTC) CHOICES project. The Contractor shall complete all project documentation by March 11, 2011.

The following enhancements are authorized to be effective on or after July 1, 2013. The Contractor shall provide resources to support the Bureau's successful deployment of these enhancement capabilities, following the Contractor's systems development methodologies:

Enhancement #9 – Provider Portal Transfer – This Enhancement requires the Contractor to transfer an operational State Medicaid Provider Portal to TennCare on a time and materials basis. TennCare requires a cost and work effort estimate and TennCare estimate approval for this enhancement prior to the contractor performing any work on this enhancement.

Enhancement #10 – SOA Infrastructure – This Enhancement requires the Contractor to implement a Service Oriented Architecture to provide an integrated platform on a time and

materials basis. TennCare requires a cost and work effort estimate and TennCare estimate approval for this enhancement prior to the contractor performing any work on this enhancement.

6. Contract section A.2.7.2.14 is deleted in its entirety and replaced with the following:

A.2.7.2.14. The Contractor shall secure documentation software that shall integrate functionality with the State approved change management system.

7. Contract section A.2.7.4.4 is deleted in its entirety and replaced with the following:

A.2.7.4.4. Integration with interChange and the State approved change management system of Documentation software.

8. Contract section A.2.11 Enhancement #9 – Provider Portal Transfer has been added as the following:

A.2.11 Enhancement #9 – Provider Portal Transfer
A.2.11.1 Summary

The Contractor shall support the Bureau's transference of the provider portal in order to enhance the technology architecture supporting the Bureau's strategies to promote provider self service, electronic claims and attachments, electronic remittance advice, and electronic provider registration, and to provide a framework for provider access management. This Enhancement begins with Control Memorandum authorization and ends upon the completion of the transfer phase. The portal will subsequently transition to the Special Project phase during which customization will occur. This Enhancement is aligned with CMS Seven Standards and Conditions as summarized in the table below.

Standard or Condition	**Alignment**
Modularity	Follows formal Systems Development methodology
MITA	Provider Enrollment: Enables electronic receipt and management of provider registration requests and demographic updates Operations: Enables electronic receipt of claims and remittance advice, improving speed, security, and efficiency
Industry Standards	Promotes compliance with HIPAA with provider managed role based access and increased transmission security Improves ability to comply with CORE/CAQH
Leverage	Leverages Portal Capabilities from another State Medicaid program Provides a framework for provider access that can be leveraged across the enterprise Reuses TCMIS provider data model
Business Results	Promotes provider self service Provides access to electronic data including historical RA and eligibility verification Transitions to a more robust web functionality without requiring provider subscription fees
Reporting	The portal will feed data to other systems where reporting shall occur
Interoperability	Supports the Bureau's interoperability strategy for provider registration and enrollment with the Center for Accountable Quality Healthcare (CAQH) and managed care contractors

A.2.11.2 System Functionality Contractor Requirements

A.2.11.2.1 The Contractor shall transfer and rebrand the operational provider portal from another state Medicaid program, “as is”. Customization of the portal and security framework will occur post transfer through the standard SCR process using special project resources.

A.2.11.2.1.1 The Contractor shall enable online provider registration capabilities

A.2.11.2.1.2 The Contractor shall enable online submission of cross over (Medicare Parts A, B, and C) claims and associated attachments, including batch.

A.2.11.2.1.3 The Contractor shall enable the ability to perform eligibility verification.

A.2.11.2.2 The Contractor shall establish necessary interfaces with the TCMIS.

A.2.11.2.3 The Contractor shall install and configure the required components of the Bureau’s COTS security access framework for the provider web portal.

A.2.11.2.4 The Contractor shall disable the current TCMIS functionality on Tennessee Anytime as part of this Enhancement or separately as a post transfer activity, as directed by the Bureau through a Control Memorandum.

A.2.11.3 Business Process Functionality Contractor Requirements

A.2.11.3.1 The Contractor shall maintain the continuity of on-going business processes before, during and after the transfer of the provider portal.

A.2.11.3.2 The Contractor shall transfer and rebrand provider web-based training materials.

A.2.11.3.3 The Contractor shall support the Bureau to establish a provider roll out communication plan.

A.2.11.3.4 The Contractor shall establish second level password reset help desk processes and promote a self service approach. The Bureau shall determine resourcing for post transfer help desk operations. Supplemental resources may be provided by the Contractor as authorized in accordance with Section A.4.3 Special Project Support.

A.2.11.4 Contractor Deliverables

A.2.11.4.1 Project Charter

A.2.11.4.2 Test Plan

A.2.11.4.3 Test Cases and outcomes

A.2.11.4.4 Completion of portal transfer

A.2.11.4.5 The following items are not applicable to this Enhancement:

A.2.11.4.5.1 Requirements Analysis

A.2.11.4.5.2 Requirements validation sessions

A.2.11.4.5.3 Detailed Systems Design

A.2.11.5 Bureau Responsibilities

A.2.11.5.1 Procure hardware, software, and maintenance directly or in accordance with Section C.3.f

A.2.11.5.2 Establish and execute a provider roll out communication plan.

A.2.11.5.3 Promote MCO and Provider association communications as defined in the communication plan.

A.2.11.5.4 Authorize funding of Provider mailings related to the communication plan

9. Contract section A.2.12 Enhancement #10 – SOA Factory Infrastructure has been added as the following:

A.2.12 Enhancement #10 – SOA Factory Infrastructure

A.2.12.1 Summary

CMS has established new Medicaid IT standards (Seven Standards and Conditions) as a requirement for enhanced Federal funding. The modularity standard requires the use of a modular flexible approach to systems development so that States can more easily change and maintain systems, as well as integrate and operate across multiple systems to deliver person centric services and benefits. Modularity is breaking down systems requirements into component parts, developing complex systems as part of a Service Oriented Architecture, (SOA).

SOA is centered on a concept of services for designing, building, and managing distributed computing infrastructure that an enterprise requires. This Enhancement begins the journey for the Bureau's transition from traditional application architecture to Service Oriented Architecture in alignment with CMS' modularity standard. This architectural change provides the foundation for transformation in how IT services support the business.

SOA is aligned with Seven Standards and Conditions as summarized in the table below.

Standard or Condition	SOA Alignment with Seven Standards and Conditions
Modularity	Establishes modular, SOA development using a formal Systems Development methodology Enables open reusable TCMIS interface standards
MITA	Aligns with and supports MITA maturity goals
Industry Standards	Improves ability to comply with CORE/CAQH Aligns with industry standards to increase interoperability
Leverage	Establishes service based systems development
Business Results	Supports the accelerating pace of business service transformation
Reporting	Provides an enterprise framework for change oversight, administration, and management
Interoperability	Enables integration and coordination of systems to produce seamless and efficient customer experiences

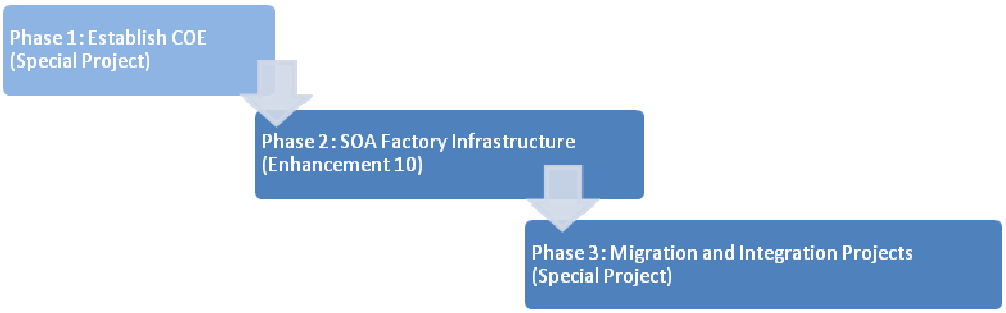
The Bureau's journey for SOA involves three phases as summarized in the bullets and figure below.

Phase 1: The first phase is the establishment of the Bureau SOA Center of Excellence (COE) which is a Special Project as defined in Control Memorandum 450.

Phase 2: The second phase, Enhancement 10 supports the Bureau's efforts to stand up a SOA capability, leveraging governance, standards, and best practices established in an existing center of excellence and utilizing a specialized resource pool. This Enhancement ends upon the completion of the establishment of the SOA platform and capability to begin migration and integration projects.

Phase 3: The third phase is the migration of existing applications and the integration of new applications to the SOA framework, during which customization will occur. This phase is hereby authorized to include Core and Flex Special Project(s), as outlined in Section A.6.5.2. The prioritization, analysis, and design may begin concurrent with Enhancement 10, however,

development shall not begin until Enhancement 10 has completed.



A.2.12.2 Contractor Responsibilities

A.2.12.2.1 Contractor shall provide staffing including Core and Flex teams.

A.2.12.2.1.1 Core Team: The Core team will have primary responsibility for SOA Governance Architecture, Design, Knowledge transfer, and Bureau COE support throughout the engagement. During the Enhancement Phase the Contractor shall ramp up to the following baseline positions for the duration of the engagement and sustain these roles through the Special Project Phase. Upon completion of the Enhancement Phase this core team is hereby authorized under SOA Core Special Project, as outlined in Section A.6.5.2.

Role	Quantity
SOA COE Program Manager	1
SOA COE Governance Consultant	1
SOA COE Business Process Analyst Lead	1
SOA Project Manager	1
SOA COE Tools Specialist SE	1
SOA COE Service Designer SE	1
SOA COE Support and Training Lead	1

A.2.12.2.1.2 Flex Team: The Flex team will have responsibility for development and operational activities, including but not limited to construction and test. During the Enhancement Phase and Special Project Phase, the Contractor may engage supplemental SOA resources (Flex Team), as needed for SOA Flex Special Project(s), with staffing and budget specified in a Control Memorandum.

A.2.12.2.1.3 Core and Flex staff shall be billed at the Special Project rates as defined in Section C.3.4

A.2.12.2.2 The Contractor shall utilize a Center of Excellence (COE) approach to assist in governing SOA activities for quality and process efficiency.

A.2.12.2.2.1 COE – The COE addresses SOA architecture solutions through a common set of well-defined technologies, methodologies and policies. The SOA activities shall be governed by the Bureau SOA Center of Excellence (COE).

A.2.12.2.3 The Contractor shall assist the Bureau in the implementation of the SOA Platform and deployment of the reference architecture defined in the Bureau COE.

A.2.12.3 Contractor Deliverables

A.2.12.3.1 Support implementation of Bureau's COTS SOA Platform including development, test, and production environments, as defined in the COE SOA Reference Architecture.

A.2.12.4 Bureau Responsibilities

A.2.12.4.1 Provide the Bureau SOA COE established during Phase 1.

A.2.12.4.2 Provide Contractor with all necessary access to Bureau facilities and systems in order to deliver the Enhancement services

A.2.12.4.3 Enable Contractor with remote access permission to systems required to perform services.

A.2.12.4.4 Provide all SOA and Security hardware and software necessary to deliver the Enhancement services, either in accordance to Section C.3.f Hardware, Software and Maintenance or by other options available to the Bureau.

10. Contract section A.3.1, is deleted in its entirety and replaced with the following:

A.3.1 Functional Areas and Business Processes

Listed below are TCMIS functional areas and operations processes, including, but not limited to:
Integration and Interfaces
Eligibility and Enrollment
Correspondence, Letters and Notices
Complaints/Grievances/Appeals
Benefit Packages
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Medicare Buy-In
Accounting/Financial/Premium Management
Drug Rebate
Claims/Encounter Claims
Third Party Liability (TPL)
Reference
Long Term Care Business Unit
Program Integrity/Surveillance and Utilization Review (SUR)/ Fraud and Abuse
Managed Care
Management and Administrative Reporting
Provider
Electronic Data Interchange (EDI)
Facilities Manager General Operations
Turnover Tasks

11. Contract section A.3.2 is deleted in its entirety and replaced with the following:

A.3.2 Integration and Interfaces

The interChange (iC) TCMIS receives and exchanges information from various resources. All integrated interfaces shall comply with HIPAA standards and transaction code sets rules. The Contractor shall maintain the TCMIS interfaces and system design according to the guidelines set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and shall act upon any technological updates, and/or changes in business processes or business relationships, as directed by the Bureau. The external interface files are used in many areas, including, but not limited to, the following functional areas. (A diagram is provided in Section A.3.2.3)
Accounting
Claims and Encounters
Drug Rebate

EPSDT
Eligibility
Enrollment
Financial
Fraud and Abuse (SUR)
Management and Administrative Reporting (MAR)
Medicare Buy-In
Premium Processing (Oracle Financials)
Provider
Reference
TPL
EDI

A summary of the existing interfaces is presented within each functional area.

12. Contract section A.3.2.1 is deleted in its entirety and replaced with the following:

A.3.2.1 Interface Listing

Detail of system interfaces is maintained in the technical documentation repository, external to the Contract. The Contractor is expected to maintain the interfaces as needed for TCMIS operations. TennCare may direct, or HP may propose changes in interfaces or documentation through the change management process or in a Control Memorandum containing a Control Directive.

13. Contract section A.3.2.3 is deleted in its entirety and replaced with the following:

A.3.2.3 TCMIS Interface Diagram

Diagrams of system interfaces are maintained in the technical documentation repository, external to the Contract. The Contractor is expected to maintain the interfaces as needed for TCMIS operations. TennCare may direct, or HP may propose changes in interfaces or documentation through the change management process or in a Control Memorandum containing a Control Directive.

14. Contract section A.3.3, paragraph 2, is deleted in its entirety and replaced with the following:

Eligibility determination for both Medicaid and TennCare Waiver eligibility is performed at the DHS under a “single point of intake” policy, or at such other State entity or by such contractor as the Bureau may designate from time to time. In the event the State determines that eligibility determination will be performed by an entity or contractor other than DHS, the State shall provide written notice to the Contractor of the applicable date of such change, and all applicable references to “DHS” contained in this Contract shall automatically be deemed to refer to the new eligibility determination entity or contractor without the requirement of a formal amendment to the Contract. TennCare shall also provide written notice to Contractor through a Control Memorandum containing a Control Directive of any changes in the eligibility provisions or requirements of this Contract that are necessitated by a change in the State entity or contractor who makes eligibility determinations on behalf of TennCare. Add and update transactions received from DHS are processed in the interChange TCMIS.

15. Contract section A.3.3.1 is deleted in its entirety and replaced with the following:

A.3.3.1 Eligibility Interface Diagram

The Contractor shall maintain the TCMIS Eligibility processes that utilize the data exchanged to and from the eligibility interfaces with which eligibility data is exchanged for TCMIS processes.

A diagram of Eligibility interfaces is maintained in the technical documentation repository, external to the Contract. The Contractor shall be expected to maintain the TCMIS Eligibility processes that utilize the data exchanged to and from these entities as needed for TCMIS operations. TennCare may direct, or HP may propose changes in Eligibility interfaces or documentation through the change management process or in a Control Memorandum containing a Control Directive.

16. Contract section A.3.3.2.3 is deleted in its entirety and replaced with the following:

A.3.3.2.3 Update enrollee and eligibility data daily in appropriate date sequence as received from external eligibility sources (e.g., Department of Health (DOH), DHS, DCS, Division of Mental Retardation Services (DMRS), DMHDD, and the Social Security Administration (SSA)), TennCare may direct, or HP may propose changes through the change management process or in a Control Memorandum containing a Control Directive

17. Contract section A.3.3.2.4 is deleted in its entirety and replaced with the following:

A.3.3.2.4 Maintain compliance with all Federal and State laws and regulations with regard to Privacy, Security, and Confidentiality throughout the TCMIS.

18. Contract section A.3.3.2.5 is deleted in its entirety and replace with the following:

A.3.3.2.5 Maintain current capabilities to create, update, and maintain an eligibility record, TennCare may direct, or HP may propose changes through the change management process or in a Control Memorandum containing a Control Directive.

19. Contract section A.3.3.2.50 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

20. Contract section A.3.3.2.59 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

21. Contract section A.3.3.3, paragraph 1, is deleted in its entirety and replaced with the following:

The following requirements are functionalities that shall be developed and implemented by the Contractor after Bureau approval. TennCare may direct, or HP may propose changes through the change management process or in a Control Memorandum containing a Control Directive.

22. Contract section A.3.3.3.3 is deleted in its entirety and replaced with the following:

A.3.3.3.3 Develop, maintain, and provide online inquiry access to enrollee eligibility input records received from, but not limited to, DHS, SSA, Bendex, Buy-In, MHDD, DOH, and DCS.

23. Contract section A.3.3.5.1 is deleted in its entirety and replaced with the following:

A.3.3.5.1 Perform activities needed to process inbound Medical Eligibility (ME) packets. This includes opening, sorting, batching, scanning and/or microfilming, entering data, filing, storing, and retrieving packets. TennCare may direct, or HP may propose changes through the change management process or in a Control Memorandum containing a Control Directive. As of the Contract Start date, the number of ME Packets received for processing is only about ten (10) packets per month.

24. Contract sections A.3.3.5.1.6 and A.3.3.5.1.7 are no longer effective pursuant to amendment execution. These sections are deleted in their entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

25. Contract section A.3.3.5.4 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

26. Contract section A.3.3.6.1 is deleted in its entirety and replaced with the following:

A.3.3.6.1 Details of Eligibility and Enrollment inputs and outputs are maintained in the technical documentation repository, external to the Contract. The Contractor shall be required to maintain interface files and associated Eligibility and Enrollment processes, as directed by

the Bureau. TennCare may direct, or HP may propose changes to Eligibility and Enrollment inputs and outputs through the change management process or in a Control Memorandum containing a Control Directive.

27. Contract section A.3.3.6.2 is deleted in its entirety and replaced with the following:

A.3.3.6.2 Enrollment Eligibility Diagram

A diagram of Enrollment and Eligibility interfaces is maintained in the technical documentation repository, external to the Contract. The Contractor shall be expected to maintain the TCMIS Enrollment and Eligibility processes that utilize the data exchanged to and from these entities as needed for TCMIS operations. TennCare may direct, or HP may propose changes to the Eligibility and Enrollment diagram through the change management process or in a Control Memorandum containing a Control Directive.

28. Contract section A.3.3.6.3 is deleted in its entirety and replaced with the following:

A.3.3.6.3 Enrollment External Files:

Details of Enrollment inputs and outputs are maintained in the technical documentation repository, external to the Contract. The Contractor shall be required to maintain interface files and associated Enrollment processes, as directed by the Bureau. TennCare may direct, or HP may propose changes to Enrollment inputs and outputs through the change management process or in a Control Memorandum containing a Control Directive.

29. Contract section A.3.4.2.3 is deleted in its entirety and replaced with the following:

A.3.4.2.3. Support history retention of correspondence including date produced, enrollee, business partner, or address where mailed.

30. Contract section A.3.4.2.6 is deleted in its entirety and replaced with the following:

A.3.4.2.6. Maintain association between letter history to an enrollee, provider, or business partner record with access to all correspondence from the enrollee, or business partner record.

31. Contract section A.3.5.3.4 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

32. Contract section A.3.5.3.12 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

33. Contract section A.3.6.1 is deleted in its entirety and replaced with the following:

A.3.6.1 Benefit Packages Overview

Contractor shall administer Benefit Packages as directed by the State. Documentation is available in the technical document repository, external to the Contract. TennCare may direct, or HP may propose changes to Benefit Packages through the change management process or in a Control Memorandum containing a Control Directive.

34. Contract section A.3.6.3.1 is deleted in its entirety and replaced with the following:

A.3.6.3.1. According to TennCare Policies and Procedures and/or rules, support and maintain covered services relating to benefit packages, drug formulary, rate setting.

35. Contract section A.3.6.3.2 is deleted in its entirety and replaced with the following:

A.3.6.3.2. Maintain rates and price data including Capitation rates, Professional service Fee-for-Service rates (e.g. Usual and Customary and Reasonable Rates, prevailing by region and specialty, and maximum fees), Drug Pricing, Hospital In and Out Patient Facility rates, nursing home per diems (Nursing Home (NH), Skilled Nursing Facility (SNF), Intermediate Care

Facility (ICF) and Intermediate Care Facility/Mentally Retarded (ICF/MR)),

36. Contract section A.3.6.3.9 is deleted in its entirety and replaced with the following:

A.3.6.3.9. Develop and maintain the capability to create, monitor, and update multiple benefit packages by effective date, including associated cost sharing amounts. Each benefit package shall continue to be uniquely identifiable within the system.

37. Contract section A.3.6.3.23.7 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

38. Contract sections A.3.6.3.23.9 and A.3.6.23.10 are no longer effective pursuant to amendment execution. These sections are deleted in their entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

39. Contract section A.3.6.3.32 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

40. Contract section A.3.7 is deleted in its entirety and replaced with the following:

A.3.7 EPSDT

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federally mandated program issued to provide health care services to children from birth to age twenty (20). The TennCare program extends the EPSDT benefit to also include the uninsured/uninsurable under age twenty-one (21) population. Tennessee's EPSDT program is referred to as "TENNderCARE", and is a full program of checkups and health care services for children already on TennCare. These services make sure babies, children, teens, and young adults receive the health care they need.

The EPSDT services include health screenings and treatment services to promote early detection of potentially chronic and disabling health conditions. Children enrolled in the EPSDT program are allowed to receive services that are not available to the general TennCare population, when the services are medically necessary to treat identified conditions.

The interChange EPSDT function serves as the Bureau's mechanism to identify and track EPSDT services and to generate notification letters to eligible individuals. The functions are supported within interChange by a series of windows and reports developed to accommodate the Bureau's needs. Immunization data, originating from the Department of Health (DOH), is stored and is accessible to be processed and viewed for an EPSDT recipient. Using claims history from MCO encounter data, several reports are created which are used to monitor the EPSDT recipient screenings, report provider costs for screenings, monitor scheduled appointments and identify providers eligible to perform EPSDT services.

The notification process identifies recipients who are new to the EPSDT program and informs them of available EPSDT services. It also notifies those recipients who are due for EPSDT screenings and those recipients who have missed an EPSDT screening. Additional EPSDT information (e.g., windows, reports and notices) can be found in the PWB within the EPSDT functional area.
The Contractor shall be required to maintain EPSDT processes in which specific EPSDT interfaces are used.

A diagram of EPSDT interfaces is maintained in the technical documentation repository, external to the Contract. The Contractor shall be expected to maintain the TCMIS EPSDT processes that utilize the data exchanged to and from these entities as needed for TCMIS operations. TennCare may direct, or HP may propose changes in EPSDT interfaces or documentation through the change management process or in a Control Memorandum containing a Control Directive.

41. Contract section A.3.7.2 is deleted in its entirety and replaced with the following:

A.3.7.2 EPSDT Inputs and Outputs

Details of EPSDT inputs and outputs are maintained in the technical documentation repository, external to the Contract. The Contractor shall be required to maintain interface files and associated EPSDT processes, as directed by the Bureau. TennCare may direct, or HP may propose changes to EPSDT inputs and outputs through the change management process or in a Control Memorandum containing a Control Directive.

42. Contract section A.3.8.2 is deleted in its entirety and replaced with the following:

A.3.8.2 Medicare Buy-In Inputs and Outputs

Details of Medicare Buy-In inputs and outputs are maintained in the technical documentation repository, external to the Contract. The Contractor shall be required to maintain interface files and associated Medicare Buy-In processes, as directed by the Bureau. TennCare may direct, or HP may propose changes to Medicare Buy-In inputs and outputs through the change management process or in a Control Memorandum containing a Control Directive.

43. In Contract section A.3.9, all references to “STARS” or “STARS (or Edison when implemented)” shall be deleted and replaced with “the State Financial System.”

44. Contract section A.3.9.4.56 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

45. Contract section A.3.9.4.58 is deleted in its entirety and replaced with the following:

A.3.9.4.58. Develop and maintain process to report principal and interest amounts owed by drug labeler on accounts receivable.

46. Contract section A.3.9.4.77 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

47. Contract section A.3.9.5.1 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

48. Contract section A.3.9.5.3 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

49. Contract section A.3.9.5.4 is deleted in its entirety and replaced with the following:

A.3.9.5.4. Develop process to systematically generate letters for Accounts Receivables.

50. Contract section A.3.9.6.1 is deleted in its entirety and replaced with the following:

A.3.9.6.1 Accounting/Financial Inputs and Outputs

Details of Accounting/Financial inputs and outputs are maintained in the technical documentation repository, external to the Contract. The Contractor shall be required to maintain interface files and associated Accounting/Financial processes, as directed by the Bureau. TennCare may direct, or HP may propose changes to Accounting/Financial inputs and outputs through the change management process or in a Control Memorandum containing a Control Directive.

51. Contract section A.3.9.6.2 is deleted in its entirety and replaced with the following:

A.3.9.6.2 Premium Inputs and Outputs

Details of Premium inputs and outputs are maintained in the technical documentation repository, external to the Contract. The Contractor shall be required to maintain interface files and associated Premium processes, as directed by the Bureau. TennCare may direct, or HP may propose changes to

Premium inputs and outputs through the change management process or in a Control Memorandum containing a Control Directive.

52. In Contract section A.3.10, all references to “STARS” shall be deleted and replaced with “State Financial System.”

53. Contract section A.3.10.1.3 is deleted in its entirety and replaced with the following:

A.3.10.1.3. Maintain a process to calculate drug rebates, create an electronic claims file for rebate data and invoices. Develop and maintain a process to allow manufacturers to access the rebate files and invoices by SFTP and notify the manufacturers when the rebate files and invoices are available.

54. Contract section A.3.10.1.6 is deleted in its entirety and replaced with the following:

A.3.10.1.6. Monitor the status of each accounts receivable; including enrollee, provider, and Drug Rebate. Report as scheduled and on request to the Bureau in aggregate and/or individual accounts, both on paper and online as directed by the Bureau.

55. Contract section A.3.10.3 is deleted in its entirety and replaced with the following:

A.3.10.3 Drug Rebate Inputs and Outputs

Details of Drug Rebate inputs and outputs are maintained in the technical documentation repository, external to the Contract. The Contractor shall be required to maintain interface files and associated Drug Rebate processes, as directed by the Bureau. TennCare may direct, or HP may propose changes to Drug Rebate inputs and outputs through the change management process or in a Control Memorandum containing a Control Directive.

56. Contract section A.3.11, paragraph 1, is deleted in its entirety and replaced with the following:

A.3.11. **Claims/Encounter Claims**

The purpose of the Claims and Encounter Claims business process is to ensure that fee-for-service (FFS) claims from enrolled providers, and encounter claims data from Managed Care Contractors are received, tracked, processed, adjudicated, and reported accurately and in a timely manner. Data from Reference, Provider, Eligibility, Enrollment, Third-Party payers, Claims History, and Financial Transactions are utilized in processing FFS claims. Claims may be received electronically or on paper. Data from Reference, Provider, Eligibility, Enrollment, Third-Party payers, and Encounter History are utilized in processing encounter claims.

57. Contract section A.3.11.1, subsection 3), is deleted in its entirety and replaced with the following:

3) Electronically by (837) batch. Managed Care Contractors use electronic file transfer protocol (SFTP) to submit encounter data.

58. Contract section A.3.11.1.1, subsection e), is deleted in its entirety and replaced with the following:

e) The Long Term Care Processing function processes claims for the MR, elderly disabled, Home and Community Based Services (HCBS) waivers, and Long Term Care institutional programs.

59. Contract section A.3.11.2 is deleted in its entirety and replaced with the following:

A.3.11.2 Capitation Payments

Monthly capitation payments are made to Managed Care Contractors (MCCs) for enrollees, including children. As of the Contract Start date, payment transactions are generated to MCOs and BHO Contractors. Planned changes include folding the BHO assignments into the MCO services.

Administrative fees are paid to a Dental Benefits Manager (DBM) for processing dental claims, and a Pharmacy Benefits Manager (PBM) for processing drug claims for the dual eligible population, some behavioral health enrollees, and special needs populations.

Capitation payment rosters are generated and distributed through an electronic file transfer to the Managed Care Contractors. The posting of payments is interfaced to the State financial accounting system.

Whenever capitation adjustments are needed, either manual adjustments may be performed through online maintenance, or automated adjustments are done prior to the monthly capitation cycle batch process.

60. Contract section A.3.11.2.1 is deleted in its entirety and replaced with the following:

A.3.11.2.1 MCO Capitation Payment Process

The TCMIS generates monthly capitation payments to each MCO for each eligible recipient enrolled in TennCare. If any changes in eligibility have occurred within a twelve (12) month period prior to the Capitation Payment run, payments are adjusted. Edit and audit reports are generated. The payment and adjustment information is passed on to the Claims functional area for processing. Additional information concerning MCO payment methodologies may be found in the individual MCC contracts.

61. Contract sections A.3.11.3.47 and A.3.11.3.48 are no longer effective pursuant to amendment execution. These sections are deleted in their entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

62. Contract section A.3.11.3.56 is deleted in its entirety and replaced with the following:

A.3.11.3.56 Maintain edits for potential and exact duplicate claims. Develop capabilities to also include cross-references between groups and rendering providers, and categories of service, in accordance with the Change Management process.

63. Contract section A.3.11.3.60 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

64. Contract section A.3.11.3.75 is deleted in its entirety and replaced with the following:

A.3.11.3.75 Manually and systematically review and resolve any claims that pend for any of the edits assigned to the Contractor, as mutually agreed with the Bureau.

65. Contract section A.3.11.3.140 is deleted in its entirety and replaced with the following:

A.3.11.3.140. Maintain functionality to deny claims with potential third-party payments including Medicare eligibility. Supply the claim submitter and/or provider with third-party information to facilitate billing the third party.

66. Contract sections A.3.11.3.195 through A.3.11.3.197 are no longer effective pursuant to amendment execution. These sections are deleted in their entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

67. Contract section A.3.11.3.198 is deleted in its entirety and replaced with the following:

A.3.11.3.198. Monitor, review, and update as needed, and work all edits and audits for a claim, unless otherwise directed by the Bureau.

68. Contract section A.3.11.4.4 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

69. Contract section A.3.11.5 is deleted in its entirety and replaced with the following:

A.3.11.5 Claims/Encounter Claims Inputs and Outputs

Details of Claims/Encounter Claims inputs and outputs are maintained in the technical documentation repository, external to the Contract. The Contractor shall be required to maintain interface files and associated Claims/Encounter Claims processes, as directed by the Bureau. TennCare may direct, or HP may propose changes to Claims/Encounter Claims inputs and outputs through the change management process or in a Control Memorandum containing a Control Directive.

70. Contract section A.3.12.2.15 is deleted in its entirety and replaced with the following:

A.3.12.2.15 Produce enrollee history profiles and copies of paid claims/encounters to assist in various collection activities and administrative processes, as directed by the Bureau.

71. Contract section A.3.12.2.18 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

72. Contract section A.3.12.2.24.2 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

73. Contract section A.3.12.2.24.4 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

74. Contract section A.3.12.2.32 is deleted in its entirety and replaced with the following:

A.3.12.2.32. Maintain the capability for the TPL system to meet the federal requirements for MMIS certification. Provide the capability to maintain online access and update capability to a single consolidated Financial Accounting system that provides for posting the details of checks received for TPL and any other cash receipts received by the Bureau. The TPL Resource File data undergo data verification to maximize data quality.

75. Contract section A.3.12.2.33 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

76. Contract section A.3.12.2.35 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

77. Contract section A.3.12.3.1 is deleted in its entirety and replaced with the following:

A.3.12.3.1 Develop and maintain functionality to receive and maintain insurance information on enrollees, including all levels of Medicare coverage and coverage dates, insurance carrier data, employer data, policyholder data, service types covered and dates, as directed by the Bureau.

78. Contract sections A.3.12.3.1.2 through A.3.12.1.5 are no longer effective pursuant to amendment execution. These sections are deleted in their entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

79. Contract section A.3.12.4 is deleted in its entirety and replaced with the following:

A.3.12.4. TPL Inputs and Outputs

External Files

Details of TPL inputs and outputs are maintained in the technical documentation repository, external to the Contract. The Contractor shall be required to maintain interface files and associated TPL processes, as directed by the Bureau. TennCare may direct, or HP may propose changes to TPL inputs

and outputs through the change management process or in a Control Memorandum containing a Control Directive.

80. Contract section A.3.13.1, paragraph 1, is deleted in its entirety and replaced with the following:

A.3.13.1. Reference Data Maintenance

The Reference Data Maintenance business area is responsible for maintaining Reference files that are a repository of current and historical pricing, prepayment utilization review, and code validation information, which is used to process fee-for-service (FFS) claims and encounter transactions. The Reference Data Maintenance business area collects, maintains and updates the information used to define and enforce TennCare policies and/or rules related to covered services, medical policy, service restrictions, and reimbursement. Other business areas (such as Claims/Encounter Processing, Third Party Resources, and SUR) access the Reference files during system processing to retrieve stored data used to make pricing determinations, post edits, or secure other Reference data. The TCMIS provides the capability for entry directly into the TCMIS Reference files, making the information immediately available for claims and encounter processing.

81. Contract section A.3.13.1, subsection 3), is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

82. Contract section A.3.13.1.3 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

83. Contract section A.3.13.1.4 is deleted in its entirety and replaced with the following:

A.3.13.1.4. <u>NDC</u>

The Drug data grouping contains data defining a drug, which includes the drug's National Drug Code (NDC), manufacturer, strength, dosage form, and package size. The majority of the data is received from a drug information provider such as First Data Bank (FDB). The drug data set is used in claims processing for editing pharmacy claims. The drug data set also supports the Drug Rebate functions of the system.

84. Contract section A.3.13.1.9 is deleted in its entirety and replaced with the following:

A.3.13.1.9. <u>Procedure Data</u>

The procedure data set supports claims processing by providing pricing methodology, price, effective dates, and restrictions related to policy or validity.

Examples of restrictions enforced by the procedure data are:

Age and sex
Allowable provider type and specialty
Place of service or tooth number
Documentation requirements
Diagnosis required and compatibility

85. Contract section A.3.13.2.14 is deleted in its entirety and replaced with the following:

A.3.13.2.14. Provide the capability and flexibility to identify and accommodate multiple reimbursement methodologies.

86. Contract section A.3.13.2.18 is deleted in its entirety and replaced with the following:

A.3.13.2.18. Maintain a user controlled Claim Edit Disposition data set with disposition information for each edit used in claims/encounter processing, including the disposition by any submission medium within claim type, including capitation payment adjustment reason codes.

For each edit error, maintain the description of the error, the related remittance Explanation of Payment (EOP) and EOB codes, and edit recycle times and frequency, with online update capability for all parameters and information.

87. Contract section A.3.13.2.19 is deleted in its entirety and replaced with the following:

A.3.13.2.19. Maintain all online audit trails of all changes made to Reference files. The audit trails shall show the changed data element, the date of the change, and the source of the change or the individual who made the change.

88. Contract section A.3.13.2.41 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

89. Contract section A.3.13.2.51 is deleted in its entirety and replaced with the following:

A.3.13.2.51. Provide audit trails for Reference file changes, including rates, codes, edit/audit changes.

90. Contract section A.3.13.2.60 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

91. Contract section A.3.13.2.71 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

92. Contract sections A.3.13.2.75 and A.3.13.2.76 are no longer effective pursuant to amendment execution. These sections are deleted in their entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

93. Contract section A.3.13.2.78.15 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

94. Contract section A.3.13.4 is deleted in its entirety and replaced with the following:

A.3.13.4 Reference Inputs and Outputs

Details of Reference inputs and outputs are maintained in the technical documentation repository, external to the Contract. The Contractor shall be required to maintain interface files and associated Reference processes, as directed by the Bureau. TennCare may direct, or HP may propose changes to Reference inputs and outputs through the change management process or in a Control Memorandum containing a Control Directive.

95. Contract section A.3.14.3.13 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

96. Contract section A.3.14.3.16 is deleted in its entirety and replaced with the following:

A.3.14.3.16. Maintain functionality to accept, track and report appeals, to include, but not limited to:

97. Contract section A.3.14.3.16.3 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

98. Contract sections A.3.14.16.6 through A.3.14.16.8 are no longer effective pursuant to amendment execution. These sections are deleted in their entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

99. Contract section A.3.14.3.36 is deleted in its entirety and replaced with the following:

A.3.14.3.36. Support functionality to produce, reconcile, and submit balancing and control

reports that reconcile all claims, including encounter claims, entered into the system to the batch processing cycle input and output counts. This process shall also apply to all claims, TAD-like claims, and encounter data accepted online real time. The reports shall be provided online and be made available as defined by the authorized user and include management level reports to account for all claims at all times.

100. Contract section A.3.15 is deleted in its entirety and replaced with the following:

A.3.15 Program Integrity/Surveillance and Utilization Review (SUR)/Fraud and Abuse

The SUR functional area of the TCMIS is used to monitor both fee-for-service and encounter claims processed by the Bureau for fraud and abuse by providers and recipients. All requirements of a SUR subsystem shall continue to be maintained and updated as required by the Bureau.

The interChange relational database provides Bureau policymakers, analysts, and other users with information to perform analysis, trending, monitoring, and managing of Medicaid data. The Fraud and Abuse/SUR subsystem encompasses three (3) components: Targeted Queries, DSSProfiler, and Ad Hoc reports.

A diagram of Fraud and Abuse components is maintained in the technical documentation repository, external to the Contract. The Contractor shall be expected to maintain the TCMIS Fraud and Abuse processes that utilize the data exchanged to and from these entities as needed for TCMIS operations. TennCare may direct, or HP may propose changes to the Fraud and Abuse diagram through the change management process or in a Control Memorandum containing a Control Directive.

101. Contract section A.3.15.1.10 is deleted in its entirety and replaced with the following:

A.3.15.1.10 Provide inquiry capability to approved users to data loaded from external agency files.

102. Contract section A.3.15.2 is deleted in its entirety and replaced with the following:

A.3.15.2 SURS Inputs and Outputs

Details of SURS inputs and outputs are maintained in the technical documentation repository, external to the Contract. The Contractor shall be required to maintain interface files and associated SURS processes, as directed by the Bureau. TennCare may direct, or HP may propose changes to SURS inputs and outputs through the change management process or in a Control Memorandum containing a Control Directive.

103. Contract section A.3.16.1, paragraph 4 and 5, are deleted in their entirety and replaced with the following:

Currently there are multiple systems that are handled by Fiscal Services to manage TennCare contracts. The goal is to make all the systems balance and reconcile for all areas. The systems are as follows:

a) Contract funding system – tracks where the contract is and the dollars committed within a certain timeframe. This system produces reports for TennCare Fiscal/Budget Unit by State fiscal year or federal fiscal year.
b) Tracking system – this system tracks the contract status during the process through completion of the contract.
c) TCMIS – processes all payments to the fee-for-service providers for claims payments for the MCC capitation payments and administrative fees.
d) State Financial System – The expenditures are tracked through a cost center code assigned by the TennCare Fiscal/Budget Unit. The assigned cost center codes are then cross-walked to selected

cost centers, which produce the draw down from CMS for matching funds. State Financial System controls the dollars paid, timing of the payments and draw down from CMS.

The Contract Management functions in interChange support the management of the following contracts:

Managed Care Organizations (MCO)
Behavioral Health Organizations (BHO)
Pharmacy Benefits Manager (PBM)
Dental Benefits Manager (DBM)
Interagency Contracts - Example: contracts with State agencies such as DCS
Other Vendor Contracts - including the contracts the Bureau enters with other organizations

104. Contract section A.3.16.4.12 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

105. Contract section A.3.17.1.11 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

106. Contract sections A.3.17.1.13 and A.3.17.1.14 are no longer effective pursuant to amendment execution. These sections are deleted in their entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

107. Contract section A.3.17.1.21 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

108. Contract section A.3.17.2 is deleted in its entirety and replaced with the following:

A.3.17.2 MAR Inputs and Outputs

Details of MAR inputs and outputs are maintained in the technical documentation repository, external to the Contract. The Contractor shall be required to maintain interface files and associated MAR processes, as directed by the Bureau. TennCare may direct, or HP may propose changes to MAR inputs and outputs through the change management process or in a Control Memorandum containing a Control Directive.

109. Contract section A.3.18.5.12 is deleted in its entirety and replaced with the following:

A.3.18.5.12. Maintain the functionality to associate and track all relevant provider numbers (e.g., Medicare provider number, TennCare Identification Number, NPI, license number, SSN, Federal Employer Identification Number (FEIN), DEA, and NCPDP).

110. Contract section A.3.18.5.16 is deleted in its entirety and replaced with the following:

A.3.18.5.16. Maintain functionality to process the CMS provider sanction electronic file, comparing data to the master TennCare provider file.

111. Contract section A.3.18.5.33 is deleted in its entirety and replaced with the following:

A.3.18.5.33. As requested by the Bureau, purge inactive provider records to an archive file on a schedule using criteria specified by the Bureau.

112. Contract section A.3.18.5.35 is deleted in its entirety and replaced with the following:

A.3.18.5.35. Facilitate the process to enable the Bureau to monitor all undeliverable mail to providers, and to verify that future mail is sent to the correct address.

113. Contract section A.3.18.5.36 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

114. Contract sections A.3.18.5.42 and A.3.18.5.43 are no longer effective pursuant to amendment execution. These sections are deleted in their entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

115. Contract section A.3.18.5.60 is deleted in its entirety and replaced with the following:

A.3.18.5.60. Develop edit capability to prevent duplicate provider enrollment during add or update transactions, as directed by the Bureau.

116. Contract section A.3.18.5.61 is deleted in its entirety and replaced with the following:

A.3.18.5.61. Provide capability to load the provider license file, as directed by the Bureau.

117. Contract sections A.3.18.5.77 through A.3.18.5.80 are no longer effective pursuant to amendment execution. These sections are deleted in their entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

118. Contract section A.3.18.6.4 is deleted in its entirety and replaced with the following:

A.3.18.6.4. Maintain system edits to support quality assurance of data in the Provider Master File/Database and make error reports available to the Bureau.

119. Contract section A.3.18.7 is deleted in its entirety and replaced with the following:

A.3.18.7 Provider Inputs and Outputs

Details of Provider inputs and outputs are maintained in the technical documentation repository, external to the Contract. The Contractor shall be required to maintain interface files and associated Provider processes, as directed by the Bureau. TennCare may direct, or HP may propose changes to Provider inputs and outputs through the change management process or in a Control Memorandum containing a Control Directive.

120. Contract section A.3.19.1.31 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

121. Contract section A.3.19.1.35 is deleted in its entirety and replaced with the following:

A.3.19.1.35. Provide staff for management and support for the TCMIS translator.

122. Contract section A.3.19.1.36 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

123. Contract section A.3.19.2 is deleted in its entirety and replaced with the following:

A.3.19.2 EDI Inputs and Outputs:

The Input and Output files for EDI are standard X12, NCPDP, HL7 files and proprietary files.

124. Contract section A.3.20.1.1 is deleted in its entirety and replaced with the following:

A.3.20.1.1 General:

The Facilities Management operations shall be performed at the facility located at 310 Great Circle Road, Nashville, TN, where the State shall provide the following facility related items:

Utilities (electricity and water)
Local Area Network (LAN) Connectivity
Wide Area Network (WAN) Connectivity, including internet access
Janitorial services

General facility security
Fire alarm and/or fire suppression system
Standard office furniture (e.g. desks, chairs, wall panels, shelves, file drawers)
Desk telephones

The Contractor shall be responsible for providing the following:
Copiers, facsimile machines, personal office equipment
Workstations for technical and support staff
Provide any additional office equipment or landscaping, if desired
Expendable supplies for Contractor staff
Liability insurance for Contractor staff and equipment

125. Contract section A.3.20.1.1.17 is deleted in its entirety and replaced with the following:

A.3.20.1.1.17. Monitor TCMIS report production to ensure that all reports are delivered on schedule.

126. Contract section A.3.20.1.1.19 is deleted in its entirety and replaced with the following:

A.3.20.1.1.19. Report or escalate to the State any identified network issues that impact application performance.

127. Contract section A.3.20.1.1.23 is deleted in its entirety and replaced with the following:

A.3.20.1.1.23. In the event that during the Contract term the hardware environment for Interchange needs to be upgraded, the Contractor shall be expected to assist in the migration of the system to the new hardware, and to test all applications during and after the migration.

128. Contract section A.3.20.1.1.32 is deleted in its entirety and replaced with the following:

A.3.20.1.1.32. Proactively provide recommendations to maintain and upgrade all hardware and software to support Contract uptime and response time.

129. Contract section A.3.20.1.1.35 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

130. Contract section A.3.2.1.1.40 is deleted in its entirety and replaced with the following:

A.3.2.1.1.40 Facilitate processing improvements such as tape to File Transfer Protocol (SFTP) file conversions, activities, and changes necessary to implement corrective action plans.

131. Contract section A.3.20.1.2.2 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

132. Contract section A.3.20.1.3.2 is deleted in its entirety and replaced with the following:

A.3.20.1.3.2. Provide administration of system security to safeguard access to data and ensure integrity, completeness, and accuracy of data; provide logons and levels of security for system users, as directed by the Bureau, as set forth in the Business Associate Agreement and in accordance with Bureau policies and procedures.

133. Contract section A.3.20.1.4.1 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

134. Contract sections A.3.20.1.5.12 and A.3.20.1.5.13 are no longer effective pursuant to amendment execution. These sections are deleted in their entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

135. Contract section A.3.20.1.5.16 is deleted in its entirety and replaced with the following:

A.3.20.1.5.16 Ensure all reporting is run on time, is correct, and is delivered according to the requirements of this Contract.

136. Contract section A.3.20.1.5.19 is deleted in its entirety and replaced with the following:

A.3.20.1.5.19. Ensure that all reports are accurately produced, as directed by the Bureau.

137. Contract section A.3.20.1.8.1 is deleted in its entirety and replaced with the following:

A.3.20.1.8.1 Ensure user understanding of system capabilities, providing user support and training, and assist users in the use of the system.

138. Contract section A.3.20.1.9.1 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

139. Contract section A.3.20.1.15.6 is deleted in its entirety and replaced with the following:

A.3.20.1.15.6. Support document management.

140. Contract section A.3.20.1.16.5 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

141. Contract section A.3.20.1.16.16 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

142. Contract section A.3.20.1.16.18 has been added as the following:

A.3.20.1.16.18 Provide a privacy official who is responsible for the development and implementation of the policies, procedures and practices according to the HIPAA Privacy and Security Rules and as amended by the Omnibus Final Rule. The Contractor must designate a contact person or office who is responsible for receiving privacy and security-related complaints and who is able to provide further information about privacy and security-related matters to State privacy officials. This personnel designation must be documented by Contractor pursuant to 42 C.F.R. 164.503(a) (2).

143. Contract section A.3.20.1.19.3 is deleted in its entirety and replaced with the following:

A.3.20.1.19.3 Treat all information obtained through Contractor performance under this Contract as confidential information and not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securing of its rights, or as otherwise provided herein, as required by federal and State laws, regulations, and policies. State or federal officials, or representatives of these parties as authorized by federal law or regulations, shall have access to all confidential information in accordance with the requirements of State and federal laws and regulations. Contractor shall notify the Bureau of any and all requests for access by another party or official pursuant to the aforementioned authorities prior to the release of information. The Bureau shall have absolute authority to determine if and when any other party is allowed to access TCMIS confidential information.

144. Contract section A.3.20.1.20.2 is deleted in its entirety and replaced with the following:

A.3.20.1.20.2. Utilize the Bureau's approved change management system and assign a unique identifying number to provide Bureau management with a means of monitoring SCRs.

145. Contract section A.3.20.1.20.3 is deleted in its entirety and replaced with the following:

A.3.20.1.20.3. Utilize the Bureau's approved change management system and assign a unique identifying number to provide Bureau management with a means of monitoring Work Requests.

146. Contract section A.3.20.1.20.6 is deleted in its entirety and replaced with the following:

A.3.20.1.20.6. The Contractor shall use the build management tools implemented as part of Enhancement #6.

147. Contract section A.3.20.1.20.11 is deleted in its entirety and replaced with the following:

A.3.20.1.20.11. The Contractor shall use the Bureau's approved change management system for documenting all change requests. Additionally the Contractor shall coordinate with the Bureau to maintain the approved change management software and the data accessed by the software.

148. Contract section A.3.20.1.20.16, paragraph a, is deleted in its entirety and replaced with the following:

a) Ensure that all libraries containing code, data, and software components utilized for development and testing shall be separate and distinct in all cases from those in production;

149. Contract section A.3.20.2.2, paragraph 1, is deleted in its entirety and replaced with the following:

A.3.20.2.2. <u>Document Imaging, Storage and Retrieval</u>

The Document Imaging System supports the activities and workflows of TCMIS users by providing access to electronic versions of documents and reports. Document Imaging provides a central image repository claims, correspondence, and supporting documentation. It facilitates the routing, review, and sharing of documents among a large user group without the risk of paper loss or destruction.

150. Contract section A.3.20.2.3.1 is deleted in its entirety and replaced with the following:

A.3.20.2.3.1. Maintain ninety-nine percent (99%) accuracy for all data entry fields, all scanning, and all imaging.

151. Contract section A.3.20.3.3 is deleted in its entirety and replaced with the following:

A.3.20.3.3 Imaging Design Diagram:

A diagram of imaging software interfaces is maintained in the technical documentation repository, external to the Contract. The Contractor shall be expected to maintain the TCMIS software imaging processes that utilize the data exchanged to and from these entities as needed for TCMIS operations. TennCare may direct, or HP may propose changes to the software imaging diagram through the change management process or in a Control Memorandum containing a Control Directive.

152. Contract section A.3.20.6.1.16 is deleted in its entirety and replaced with the following:

A.3.20.6.1.16. Provide support services for the HCFA Customer Relationship Management (CRM) System, as directed by the Bureau.

153. Contract section A.3.20.6.1.24 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

154. Contract section A.3.20.11.1.5 is deleted in its entirety and replaced with the following:

A.3.20.11.1.5. Support requirements for electronic TennCare Eligibility Verification.

155. Contract section A.3.20.11.1.22 is deleted in its entirety and replaced with the following:

A.3.20.11.1.22 Report any privacy and security violations immediately upon becoming aware to the appropriate Bureau personnel.

156. Contract section A.3.21.4.1.1 is deleted in its entirety and replaced with the following:

A.3.21.4.1.1. The Contractor shall supply an estimate of the number and type of personnel needed to operate the equipment and other functions associated with the operation of the TCMIS infrastructure. This inventory shall be separated by type of activity of the personnel, including but not limited to the following:

Data processing staff
Computer operations staff
Systems analysts
Systems programmers
Database administrators/designers
Programmer analysts
Business analysts
Project management staff
Data entry and imaging operators
Provider services staff
Administrative staff
Trainers
Coordinators
Supply clerks and administrative assistants
Managers

157. In Contract section A.4, paragraph 1, has been added as the following:

A.4 Change Management

The Change Management process supports systematic day to day functions through Maintenance Tasks, Modification Tasks, and Special Projects.

158. In Contract section A.4, all references to “Team Track” shall be deleted and replaced with “State approved change management system.”

159. Contract section A.4.1, paragraph 1, is deleted in its entirety and replaced with the following:

A.4.1. Maintenance Tasks

There is an existing workload of Work Requests (WRs) that shall continue to be addressed under this Contract term. The Contractor shall be responsible for managing and tracking the WRs. The Contractor shall be responsible for maintaining the TCMIS throughout the term of this Contract. This Section describes how future fixes to the system shall be categorized, the staffing requirements, the milestones that shall be met within task activities, and how Bureau and Contractor responsibilities are defined.

160. Contract section A.4.1.1.7 is deleted in its entirety and replaced with the following:

A.4.1.1.7. Changes to the job scripts or system parameters concerning the frequency, number, and media of reports or data feeds;

161. Contract section A.4.1.3 is deleted in its entirety and replaced with the following:

A.4.1.3. Maintenance Task Activities

The person identifying the need or potential need for system maintenance shall promptly initiate a Work Request (WR) indicating the nature of the maintenance activity required. The Contractor shall follow the Change Order process to work the change request. The Contractor shall make reporting available to the Bureau on the timeliness of the processing of maintenance requests, including the identification of the percent of maintenance requests performed within ten (10) business days. The Contractor shall have the general discretion to assign Maintenance and Modifications staff to maintenance support as required to complete requests timely and will coordinate with the Project Director to address changes in Bureau needs and priorities. The Bureau will perform requirements validation, test validation and post-implementation review of maintenance requests timely so the requests may be closed in the change management tracking tool.

Weekly status meetings shall be held between the Bureau and Contractor. The weekly meetings shall allow the Contractor to report progress against schedules and any necessary schedule revisions, and shall allow for discussion of specific details where necessary. The Contractor shall document these status meetings as meeting minutes.

In addition, the Contractor shall be required to coordinate with the Bureau to use State approved change management system to maintain all work requests and will include all relevant associated information.

162. Contract section A.4.1.4.3 is deleted in its entirety and replaced with the following:

A.4.1.4.3. Submit Work Requests or Corrective Action Plans, as appropriate, regarding all deficiencies.

163. Contract section A.4.1.4.6 is deleted in its entirety and replaced with the following:

A.4.1.4.6. Provide status meeting minutes to the Bureau within three (3) business days after the meeting.

164. Contract section A.4.1.4.22 is deleted in its entirety and replaced with the following:

A.4.1.4.22 Ensure all daily, weekly, monthly, quarterly, annual and on request cycles are run correctly and on time.

165. Contract section A.4.1.4.26 is deleted in its entirety and replaced with the following:

A.4.1.4.26. Proactively provide recommendations to maintain and as approved by the State in writing, upgrade all hardware and software to support Contract uptime and response time.

166. Contract section A.4.2.3.2 is deleted in its entirety and replaced with the following:

A.4.2.3.2 The Contractor shall post in the State approve change management system for Bureau review an estimated scale of system modification efforts, such as but not limited to "small", "medium", "large", or "project", within five (5) business days of receipt, unless specified in the SCR (that may reduce that time frame) or for large project planning (that may increase that time frame). The response shall consist of a preliminary, high-level, non-binding scale of the effort required to complete the change. The definition of scale, such as but not limited to "small", "medium", "large", or "project" may be established and modified through mutual agreement as documented in a Control Memorandum with a Control Directive. The purpose of the preliminary scale of effort is to quickly assess whether the value of the request exceeds the cost of performing the request. As requirements are further defined and a solution is designed, the preliminary estimate will be updated with a revised estimate(s).

167. Contract section A.4.2.5.17 is deleted in its entirety and replaced with the following:

A.4.2.5.17. Submit acceptance test results for review and approval.

168. Contract section A.4.2.5.25 is deleted in its entirety and replaced with the following:

A.4.2.5.25. Document all status meetings in minutes and provide minutes to the Bureau within three (3) business days after the meeting.

169. Contract section A.4.3 is deleted in its entirety and replaced with the following:

A.4.3 Special Project Support

There may be new projects that do not fall into normal change requests categories. These are typically large projects where the level of effort is significant and the duration is extended. These projects will not go through the normal change process and will be staffed and managed through dedicated resources, using the billable rates defined in the Contract.

Once a project is designated as special, the Contractor shall coordinate with the Bureau to perform an estimate and procure the additional funding approval.

170. Contract section A.4.3.1 is deleted in its entirety and replaced with the following:

A.4.3.1. Special Project Criteria

The criteria for a special project are as follows:

A.4.3.1.1 The staff requirements of the project are such that they cannot be performed using the existing staff or skill sets; or

A.4.3.1.2 The duration of the project is expected to extend beyond six (6) months; or

A.4.3.2.3 The number of resources is expected to be considerable (e.g. more than five (5) dedicated resources); or

A.4.3.2.4 The project is of such complexity that a dedicated Project Manager is required, or

A.4.3.2.5 A temporary increase of supplemental staff is needed to address a business need

Special Projects Staffing compensation shall be based on the Payment Rates detailed in this Contract for units of service authorized by the Bureau. The Bureau shall compensate the Contractor for Project work based on the hourly rates detailed in this Contract. The Contractor shall submit monthly invoices, in form and substance agreed to with the Bureau, with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall, at a minimum, include the name of each individual, the individual's job title, the number of hours worked during the period, the applicable payment rate, the total compensation requested for the individual, and the total amount due the Contractor for the period invoiced.

171. Contract section A.4.3.2.3 is deleted in its entirety and replaced with the following:

A.4.3.2.3. The Contractor shall identify possible future initiatives not already identified in the Contract that shall have an effect on the Bureau operations. The Contractor shall notify and submit a preliminary analysis to the Bureau pertaining to the initiative.

172. Contract Section A.5.1.1.3 is deleted in its entirety and replaced with the following:

A.5.1.1.3 Provide system security to safeguard access to data and ensure integrity, completeness, and accuracy of data. Provide logons and levels of security for system users, and in accordance with HIPAA Privacy, Security, and Confidentiality requirements.

173. Contract sections A.5.4.2.3 through A.5.4.2.5 are no longer effective pursuant to amendment execution. These sections are deleted in their entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

174. Contract section A.5.6.3.1 is deleted in its entirety and replaced with the following:

A.5.6.3.1 Compliance with Federal and State Standards

The system shall meet all federal requirements for certification as prescribed in the State Medicaid Manual, Part 11, as well as Titles 42 and 45 of the CFR. In addition, the Contractor shall assist the Bureau in systems and operational compliance efforts with ongoing legislation passed at the federal or State level.

175. Contract section A.5.6.3.1.1 is deleted in its entirety and replaced with the following:

A.5.6.3.1.1 Privacy, Security and Confidentiality

Contractor shall ensure it continuously meets all federal regulations and State laws, as amended, regarding standards for privacy, security, and confidentiality of individual data, referred to as, but not limited to, individually identifiable data, protected health information, personally identifiable information, substance abuse and mental health information (SAMHSA), federal tax information (IRC), genetic information (GINA), and financial information (GLBA). Contractor's failure to comply with the legal standards, requirements, and State policies may result in sanctions as set forth in Attachment B.1.4 and B.2.

176. Contract section A.5.6.3.2 is deleted in its entirety and replaced with the following:

A.5.6.3.2 Privacy, Security, Confidentiality, and Auditing

The Contractor shall ensure that the TCMIS enhancements and operations are in accordance with both State and federal regulations and guidelines related to privacy, security, confidentiality, and auditing.

177. Contract section A.5.6.3.2.1, paragraph 2, is deleted in its entirety and replaced with the following:

The Contractor shall develop a plan for the physical and system security for each of its facilities used in meeting the requirements of this Contract. This plan shall use the NIST Special Publication 800-18 (Guide for Developing Security Plans for Federal Systems), or the then current version. This plan shall be submitted initially to the Bureau within thirty (30) calendar days of the Contract Start date. The Contractor shall submit an updated plan annually no later than the anniversary date of the Contract Start date. This plan shall identify all potential security threats and hazards to the physical sites, systems and network, including the probability of occurrence, and shall identify the assets and controls to protect against such threats and hazards. The Contractor may submit this plan in conjunction with the business continuity and disaster recovery plan.

178. Contract section A.5.6.3.2.2 is deleted in its entirety and replaced with the following:

A.5.6.3.2.2 Confidentiality

Contractor shall comply with all Confidentiality provisions set forth in this Contract, including but not limited to, Section E and Attachment C.

179. Contract section A.5.6.3.2.3, paragraph 3, is deleted in its entirety and replaced with the following:

An independent auditor shall perform SSAE-16 Type I audits at the Contractor's operations site annually, beginning after the end of each State Fiscal Year and submitted to the Bureau no later than four (4) months after the start of the subsequent State Fiscal Year, unless otherwise approved by the Bureau. Control objectives of the SSAE-16 Audit will be specified and approved by TennCare. Findings and action plans shall be submitted to the Bureau. No additional funding shall be allocated to perform the audit tasks. Therefore, these audits should be included in the price of this Contract. The Contractor and all subcontractors shall provide reasonable access to all facilities and assistance to the Bureau and federal representatives. All inspections and evaluations shall be performed in such a manner as will not unduly delay work. The Contractor shall also provide support to the Bureau, including selection of samples, production of hard-copy documents, and gathering of other required data. The Contractor's staff shall assist Bureau staff in responding to CMS inquiries. This level of support shall also be provided to all other State audit agencies or their designees.

180. Contract sections A.5.6.6.3 through A.5.6.6.7 are no longer effective pursuant to amendment execution. These sections are deleted in their entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

181. Contract section A.5.6.8.3 is deleted in its entirety and replaced with the following:

A.5.6.8.3. The Contractor shall ensure that data maintained by the system is properly and routinely purged, archived, and protected from destruction, as directed by the Bureau. Some data, as defined by the Bureau, shall never be purged, or shall be purged on a different schedule (i.e., lifetime procedure claims). All data purge schedules and procedures shall be approved in advance by the Bureau. Purged data shall be retained in electronic media specified by the Bureau. Data, including payment information, shall be archived according to Bureau standards.

182. In Contract section A.5.7.2, all references to "STARS" or "STARS system" shall be deleted and replaced with "State Financial System."

183. Contract section A.5.7.3.18 is deleted in its entirety and replaced with the following:

A.5.7.3.18. Ensure that all reports are accurately produced, as directed by the Bureau.

184. Contract sections A.5.7.3.35 and A.5.7.3.36 are no longer effective pursuant to amendment execution. These sections are deleted in their entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

185. Contract section A.5.7.3.52 is deleted in its entirety and replaced with the following:

A.5.7.3.52. Generate CMS reports by no later than six (6) weeks prior to the federal deadline, or as defined by the Bureau.

186. Contract section A.5.8.2.9.15 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

187. Contract section A.6.1 is deleted in its entirety and replaced with the following:

A.6.1 Facilities Manager Staffing Contractor Requirements

Upon the Effective Date of the Contract, the Contractor shall have sufficient staff to operate the baseline system and business processes contained in the Contract. It is the intent of TennCare to have the modified TCMIS fully operational, by the Modified Operations Start Date. The transition from the baseline staffing levels on the Effective Date of the Contract to the Modified Operations staffing levels shall be completed by the Modified Operations Start Date.

All personnel shall be the employees or contracted staff of the Contractor and shall be fully qualified to perform the work required in this Contract. The Contractor shall ensure that all staff members possess the necessary technical background, education, and skills to perform in the various environments and capacities necessary to support the TCMIS infrastructure.

The Contractor shall have total responsibility for hiring and management of any and all Contractor staff as determined necessary to perform the services in accordance with the terms of this Contract and shall provide a proposed Resource Level Staffing Plan for review and approval by TennCare. The Plan shall include the Key Staff identified below performing the work set forth in the corresponding job descriptions. The Contractor's failure to provide and maintain Key Staff may result in liquidated damages as set forth in Attachment B.

The Bureau shall have the absolute right to approve or disapprove the Contractor's and any subcontractor's staff, or to require the removal or reassignment of any Contractor employee or subcontractor personnel found unacceptable to the Bureau for work done under this Contract only. The Contractor shall provide the technical experts and/or high level management, herein referred to as "Key Staff," necessary for TCMIS project operations, which are detailed in Section A.6.2. The Contractor shall demonstrate to TennCare that Contractor has the Key Staff to perform the Contract. Therefore, the Contractor shall comply with the below staff requirements.

The Contractor shall have the general discretion to assign Maintenance and Modifications staff to maintenance support as required to complete requests timely and will coordinate with the Project Director to address changes in Bureau needs and priorities. The Contractor shall reallocate staffing resources based on current TennCare program needs and current TennCare structure. Additionally, reallocations may be requested of the Contractor by TennCare management by Control Memorandum. The parties recognize that the timely completion of maintenance and modifications activities requires timely cooperation from the Bureau for requirements validation, test validation and post-implementation review of Maintenance and Modification requests. The Contractor shall be held harmless for non-compliance with performance standards related to the processes performed by the individuals re-assigned to other needs by the Bureau.

Mutual agreement to modify Key Personnel titles or staffing classification (Key, Maintenance and Modifications, Operations Processing) or staffing levels, including a mutually agreed rate for credit or increase per staff, shall be documented by Control Memorandum. The parties may agree to plan for a lower staff level than described in this Section A.6, but reductions may be restored by mutual agreement of the parties through a Control Memorandum to meet other contractual performance standards or other business needs.

188. Contract section A.6.2 is deleted in its entirety and replaced with the following:

A.6.2. Key Staff Requirements

The Contractor is required to fill all Key Staff positions described below with personnel acceptable to the State, and to keep the Key Staff positions filled at all times during this Contract, unless otherwise directed by the State in a Control Memorandum. The Contractor shall provide the Bureau with the resumes of all Key Staff personnel who the Contractor proposes to assign to any aspect of the performance of this Contract. Should any Key Staff member end his/her engagement with the TCMIS project, the replacement Key Staff shall be of similar or greater experience and be approved by the State. The Contractor shall notify the Bureau by Control Memorandum of any change in Key Staff at least thirty (30) days prior to the change or within one (1) business day (whichever occurs first) of Contractor receiving a resignation notice from a Key Staff member. If a proposed replacement Key Staff member is not already on-site at the Bureau and/or already working on TCMIS, the Contractor shall deliver a statement to the State, along with the person's resume, signed by the proposed Key Staff member confirming that s/he has agreed to a possible relocation for the TCMIS project. Unless otherwise approved by the Bureau in a Control Memorandum, failure by the Contractor to make a good faith effort to replace a Key Staff member and/or to submit the resume of an appropriately qualified individual for the State's consideration within sixty (60) days of the date the Contractor notified the Bureau of the Key Personnel vacancy may result in liquidated damages as set forth in Attachment B. If a candidate that is proposed by the Contractor is rejected by the Bureau, a thirty (30) day period for the

Contractor to fill the vacancy will begin upon receipt of the State's rejection by the Contractor. This process shall continue until the Contractor has proposed and obtained the services of a Key Personnel replacement that is acceptable to the Bureau.

Key Staff are defined as:

a. Account Manager
b. Deputy Account Manager
c. Project Management Office (PMO) Manager
d. Operations Processing Manager
e. TCMIS Systems Manager
f. TCMIS Deputy Systems Manager
g. Quality and Process Manager

The roles of the Deputy Account Manager and the Enhancement Project Manager are not required to be filled on the Effective Date of the Contract. However, the Contractor shall fill these positions as quickly as reasonably possible and no later than the Modified Operations start date.

The Key Personnel roles are described below.

189. Contract section A.6.2.1, paragraph 1, is deleted in its entirety and replaced with the following:

The Account Manager shall work on-site and be dedicated full time to the work required under this Contract, which includes, but is not limited to the following: directs and coordinates overall activities and shall be responsible for the complete TCMIS account including the administration of ongoing support and management of Start-Up activities, Operations and Enhancement implementations. This individual shall be responsible for managing all facets of this Contract, which shall include the following responsibilities:

190. Contract section A.6.2.2 is deleted in its entirety and replaced with the following:

The Deputy Account Manager shall work on-site and be dedicated full time to working directly with the Account Manager to assist in overseeing all tasks associated with managing the TCMIS account, including but not limited to Privacy, Security, and Confidentiality.

191. Contract section A.6.2.3 is deleted in its entirety and replaced with the following:

A.6.2.3. Project Management Office (PMO) Manager

The Project Management Office Manager shall work on-site and be dedicated full time to coordinate overall activities associated with enhancements, applications development and support. Other responsibilities include:

a. Work with other resources to develop and adhere to project implementation plan.
b. Disseminate information to associates and stakeholders.
c. Direct workers in problem resolution and monitoring.
d. Maintain records, prepare and distribute reports.
e. Collaborate with other management to meet Bureau and Contractor objectives.
f. Track and report on the progress of testing and serve as liaison to Bureau staff and Contractor's systems staff.

192. Contract section A.6.2.4, paragraph 1, is deleted in its entirety and replaced with the following:

The Operations Processing Manager shall work on-site and be dedicated full time to handle the following responsibilities:

193. Contract section A.6.2.5 is no longer effective pursuant to amendment execution. This section is deleted in its entirety and replaced with the following: [INTENTIONALLY LEFT BLANK].

194. Contract section A.6.2.6, paragraph 1, is deleted in its entirety and replaced with the following:

The TCMIS Systems Manager shall work on-site and be dedicated full time to handle the following responsibilities:

195. Contract section A.6.2.7 is deleted in its entirety and replaced with the following:

A.6.2.7. TCMIS Deputy Systems Manager

The TCMIS Deputy Systems Manager shall work on-site and be dedicated full time to support the Technical Services Director in overseeing the technical organization and account support functions. Other responsibilities include:

a. Provides direct responsibility for the technical delivery of the Enhancement services, which includes the leadership and coordination of leveraged teams, local staff, and third party consulting teams
b. Acts as the backup to the Technical Services Director
c. Performs the responsibilities of the Functional Manager for the Business Intelligence/Data Warehouse/MAR areas
d. Leads the Architect group to develop and enforce standards, reviews and develop solutions

196. Contract section A.6.2.8 is deleted in its entirety and replaced with the following:

A.6.2.8. Quality and Process Manager

The Quality and Process Manager shall work on-site and be dedicated full time to provide leadership and direction for account quality and process team responsible for:

a. Directs performance measurement, management to achieve service excellence and contract compliance
b. Ensures account-wide performance and quality goals are met to the requirements of the customer.
c. Develops, implements, communicates and manages a quality assurance plan including goals, objectives, policies, procedures and systems.
d. Manages process and product audits and creates audit schedules.
e. Uses continuous process improvement techniques, identifying and proactively addressing quality, and/or productivity improvement opportunities.
f. Establishes and implements a communication strategy for the improvement and awareness of quality issues across all departments.

197. Contract section A.6.3 is deleted in its entirety and replaced with the following:

A.6.3. Maintenance and Modifications Staffing Contractor Requirements

The Contractor shall provide staffing to meet the requirements and performance measures defined within the Contract. Additionally, the Contractor shall provide, at a minimum, the staffing levels stated in this section for Maintenance and Modification staff (Full Time Equivalent). The Contractor shall, at a minimum, have one hundred percent (100%) of the Total Maintenance and Modifications positions, as required to fulfill the scope of services specified in this Contract and reported monthly. Staffing level measurement will be based on the effective date of this amendment, with a sixty (60) business day grace period for vacancies and new positions. Unless otherwise approved by the Bureau, failure to meet

this standard may result in liquidated damages as set forth in Attachment B. If a situation arises in which the standard is met but vacancies in a particular category or role become a concern, the Bureau may require the Contractor to fill a vacant position in a reasonable period of time.

Staff to be included within the Maintenance and Modification Staff shall include, but not be limited to, the job categories and quantity of staff as defined in the following table, unless otherwise approved through control memorandum:

Category	Minimum Staff At Contract Effective Date	Minimum Staff At Modified Operations Start Date
Systems	49	84
Business Services	22	40
Project Management	16	33
Infrastructure	15	23
DBA	0	2
Leadership	2	6
Total	104	188

The table below lists the Maintenance and Modifications staff effective beginning on July 1, 2013.

Category	Staff Effective 07/01/2013
Tech Services	86
PMO	16
Infrastructure	22
Enterprise	23
Security	6
Quality	32
Business Intelligence/ Data Warehouse	14
Total	199

Unless otherwise mutually agreed to and approved by the State through a Control Memorandum, the following are the dedicated and on-site staff requirements:

- Dedicated Staff:
    - At least ninety-five percent (95%) of the actual Maintenance and Modification staff, in total, shall be dedicated to the TCMIS Project.
- On-Site Staff:
    - At least eighty-five percent (85%) of the actual Maintenance and Modification staff, in total, shall be on-site or meet the exception criteria. This is measured by the number of on-site staff plus the number of off-site staff who meet the exception criteria as listed in the table below, divided by the number of actual Maintenance and Modification staff; and

- At least seventy percent (70%) of the actual Maintenance and Modification staff, in total, shall be on-site. This is measured by the number of on-site staff divided by the number of actual Maintenance and Modification staff.

Role	Category	Minimum Requirements
Developer	Tech Services BI/DW	3 years experience with applicable technology such as; C, PL/SQL, SQL, UNIX, PowerBuilder, SOA, ASP.net, C#.net, FileNet P8, CMod, Siebel, interchange, etc.
DBA	Infrastructure	3 years experience with applicable technology such as Oracle or SQL server
SA	Infrastructure	3 years experience with applicable technology such as UNIX or Windows
Testing	Quality	5 years experience with structured functional testing 2 years experience testing interChange projects 2 years experience with HP Quality Center
EDI Business Analyst	Tech Services	1 year experience with Edifecs tool suite 2 years experience with healthcare

Maintenance and Modification staff will be calculated at a pro-rated head count based on start and end dates and based on level of dedication. Use of Maintenance and Modifications resources is important to ensure that knowledge of base operations is incorporated into Enhancements, Assessments, and Special Projects and to promote knowledge of these projects being retained after project deployment. Roles that are established to support Maintenance and Modifications through the remainder of the Contract and that are staffed shall be included in the measurement of Maintenance and Modifications headcount for a given period, even though they may also be supporting Enhancement, Assessment, or Special Project activity for the same period. Maintenance and Modifications staff time shall be billed under the C.3.3 Operations Cost fixed price and not the C.3.4 Special Project rates. Roles that are established to support an Enhancement, Assessment, or Special Project that will end upon completion of that Project shall not be included in the measurement of Maintenance and Modifications headcount; instead, they shall be measured against the staffing plan for each Project.

High-level descriptions of the Maintenance and Modifications personnel categories and roles are listed below.

A.6.3.1. Business Intelligence/ Data Warehouse

A.6.3.1.1. Dashboard Developers

a. Design and Build interactive Dashboard and reporting solutions using account dashboard tools and standards
b. Model, build and maintain universes and data marts based on business requirements
c. Test reports and dashboards against universes and database connections to verify quality of the results

A.6.3.1.2. Data Governance/Quality

a. Develops, maintains and promotes processes for data governance
b. Coordinates interaction between the Bureau business users, the Bureau Healthcare Informatics (HCI) group and the HP staff for planning, collaboration and prioritization
c. Investigates, designs solutions, and resolves priority data quality issues according to account standards and processes; escalating issues as appropriate

A.6.3.1.3. Developers

a. Supports the technical aspects of the SDLC (e.g., design, development, unit test and implementation) in accordance with account standards and processes for all modifications related to Business Intelligence or the Data Warehouse
b. Collaborate with Business Services Analysts, PMO and business users to define project scope, project deliverables, and implementation dates
c. Research, analyze, and make recommendations pertaining to the implementation of new processes, tools, and technologies
d. Monitor and ensure resolutions of performance issues

A.6.3.2. <u>Enterprise</u>

A.6.3.2.1. Architects

a. Guide the design, development and support of technical solutions
b. Research and recommend new technologies, standards and tools
c. Coordinate with the Bureau to assist in establishing and executing the technology strategy

A.6.3.2.2. Functional Managers

a. Responsible for all work in their functional areas
b. Coordination with Project Managers
c. Day-to-day maintenance of the system
d. Development of, and adherence to, processes and procedures
e. Coordinate with the Project Manager to ensure that resources are available for WR/SCR work based upon prioritization
f. Review task, status and progress schedules to promote accurate, timely and cost effective completion
g. Provide status of assignments to management

A.6.3.2.3. Software Configuration Managers

a. Work with Development and Testing staff configuring, staging and deploying releases to the test and production environments
b. Work to automate builds and software deployments

A.6.3.2.4. Technical Writers/Trainers

a. Analyze and interpret technical information to compile and record user and technical documentation
b. Work with PMO and Technical Services to produce quality documentation for the SDLC process utilizing documentation standards
c. Compose quality documentation of the TCMIS infrastructure and inter-related business and operation functions
d. Design, develop and conduct training programs and materials to instruct employees and users
e. Evaluate training and performance support materials to ensure that they are specific for the business process and up-to-date

f. Coordinate and facilitate user training sessions in accordance with the Annual Training Plan and maintain status reports documenting training sessions provided and attendees

A.6.3.2.5. General Support

a. Provide general administrative support to the account
b. Provide assistance with notification process and reporting.

A.6.3.3. Infrastructure

A.6.3.3.1. Database Administrator

a. Design, install, monitor, maintain, and regulate production and test databases while ensuring high levels of data accessibility.
b. Work with application development or modification staff to develop or modify database architectures and coding standards.
c. Monitor database system details within the database, including stored procedures, execution time, and implement improvements for efficiency.

A.6.3.3.2. Production Support

a. Operate and monitor computer and peripheral equipment as required
b. Observe and document error messages, job step executions, faulty output or machine interruptions
c. Determine and communicate source of computer problems (user access, hardware, software) and advise appropriate staff
d. Serve as liaison between Contractor IT staff and Computer operations staff to resolve problems
e. Document details of issues and resolutions and contact appropriate staff to resolve job execution issues
f. Facilitate the use of input data as needed for job executions, (e.g., data or file overrides, parameter dates, and control numbers)

A.6.3.3.3. Systems Administrator

a. Ensure integrity by evaluating, implementing, and managing software/hardware solutions needed for operational support.
b. Implement standards and procedures for hardware and software and recommend solutions to enhance functionality.
c. Serve as liaison between the Bureau and other entities to resolve network and hardware problems.
e. Participate as needed, in the implementation of enhancements or modified systems functions.
f. Provide user or staff orientation on network operations, hardware, or software.
g. Provide complete control and accounting of all data received, stored, used or transmitted by the Contractor to assure administrative, physical, and technical security of the data.

A.6.3.4. Project Management Office

A.6.3.4.1. Project Manager

a. Responsible for interfacing with the Business User on status, prioritization and resolving questions
b. Report on status of prioritized items
c. Manage scope and definition processes for SCRs

d. Give direction, when needed, to Information Specialists and Information Analysts
e. Work with BA to ensure business needs are met
f. Work with Information Specialist, Analysts and TDTM to ensure that technical specifications are met.

A.6.3.4.2. PMO Support

a. Provide system support and research analysis for project management and customer support. (e.g., status reporting, risk analysis, change request coordination, and release management)
b. Capture and report on project metrics such as schedule and cost performance, project management quality assurance, project close out and post implementation evaluation status or issues
c. Work closely with PMO to provide project planning analysis, quality assurance, and resource planning, and providing project plan documentation (e.g., scope, resources, requirements, and schedule)

A.6.3.5. Quality

A.6.3.5.1. Testers

a. Assist in test planning and the development of the Functional Test Plan, including the development support and maintenance of test cases
b. Identify test environment, interfaces, and data requirements
c. Perform Functional/Integration Testing and Regression Testing
d. Identify, track, and coordinate defects
e. Perform diagnosis on problems encountered and provide detailed analysis of each

A.6.3.5.2. Process/Performance Specialist

a. Monitors and performs quality assurance, quality control, and process monitoring activities defined by the Enterprise Quality Assurance Plan and contractual thresholds
b. Responsible for the Performance Reporting System and supporting reporting deliverables to meet contract service level agreements (SLA's)
c. Develops and implements quality measures and business process modeling to facilitate process improvement activities for internal and Bureau account purposes
d. Confirms compliance to processes via internal auditing and performance measure analysis; to include monitoring and tracking corrective actions and root cause analyses to closure

A.6.3.6. Security

A.6.3.6.1. Developer

a. Provide support in the areas of vulnerability management tools, risk analysis and reporting
b. Review of technical and operational security controls to ensure the compliance to information technology security standards
c. Promote secure configuration and coding standards with developers for new environments and technologies
d. Assist in security due diligence and analysis of third-party tools, vendors, and systems

A.6.3.6.2. Security and Privacy Officer

a. Serve as the HIPAA Privacy Officer and the HIPAA Security Officer as required in the HIPAA Privacy and Security Regulations.
b. Prioritize security initiatives
c. Investigate security breaches
d. Liaison with TennCare Privacy and Security Officials

A.6.3.6.3. Provisioning Analyst

a. Supplement the TennCare IS security team for identity and access administration

A.6.3.7. Technical Services

A.6.3.7.1. Business Services Analyst

a. Work directly with requestor to ensure that business specifications are defined.
b. Formulates business scope and objectives, serving as the subject matter expert in various functional areas.
c. Serve as liaison between the Bureau staff and technical solutions staff to identify business processes and systems requirements.
d. Develop test scenarios and execute test cases to ensure that changes meet business requirements.
e. Define data requirements and gather and validate information.
f. Perform program and system validation and testing.
g. Work to define needed program changes to resolve operating problems.
h. Specify computational data and methods to be applied develop test data and define expected results.

A.6.3.7.2. Developer

a. Primary responsibility is for delivering solutions for WR/SCR work.
b. Design and construct IT solutions, defining project scope, plans and deliverables.
c. Collaborate with others, and work with BAs to ensure that business requirements are met.
d. Work with BA to develop specifications.
e. Develop technical detailed design documentation for SCRs.
f. Provide technical assistance to BA in System Testing.
g. Provide technical assistance to End User/TCIS for User Acceptance Testing.
h. Perform estimates for WR/SCRs.
i. Work to meet customer's expectations in prioritization.

198. Contract section A.6.4 is deleted in its entirety and replaced with the following:

A.6.4. Operations Process Staffing

The Contractor shall provide, at a minimum, the staffing levels stated below for Mailroom, Provider Support Service, Data Capture staffing (Full Time Equivalent) as needed to perform duties as required or to support this Contract. The Contractor shall, at a minimum, have one hundred percent (100%) of the total Operations Process positions, as required to fulfill the scope of services specified in this Contract. Staffing level measurement will be based on a sixty (60) business day grace period for vacancies and new positions.

Category	Number of Staff (FTEs)
Mailroom	12
Provider Support	26
Data Capture	23

Total Operations Process	61

A.6.4.1. Mailroom Services

The Mailroom team shall be staffed as follows:

Role	Number of Staff
Mailroom Clerk	11
Mailroom Supervisor	1

A.6.4.1.1. Mailroom Clerk Role:

a. Receive, sort, screen and distribute mail;
b. Batch, index, image and enumerate documents;
c. Facilitating Claims record management; and
d. Perform Courier duties for collecting and delivering various materials and documents to and from multiple destinations.

A.6.4.2. Provider Support Services

The Contractor shall be required to provide staff to perform provider support functions. These staffing levels shall be evaluated by the Contractor and the Bureau on a quarterly basis to ensure that adequate staff is present to meet the call volumes.

Within the Provider Support team shall be staffed as follows:

Role	Number of Staff
Provider Support Team Leader	1
Provider and Suspense Processing Support	25

The Provider Support Service staffing level assumes that each customer service representative is able to respond to eight (8) to ten (10) calls per day. At a minimum, representatives shall provide status information relating to issues. This status may be that the problem is fixed, the resolution has been identified and shall be completed within a certain timeframe, or the Contractor is awaiting direction from the Bureau on which action is necessary.

The Suspense Processing staff shall support the finalization of at least eight thousand, one hundred (8,100) claims per week. However, the Contractor shall allow for a fluctuation of volumes up to twenty thousand (20,000) finalized claims per week. In the event that policy changes or other external factors cause an increase in the weekly suspense volumes, the excess volume shall be invoiced by the Contractor by the quarterly Excess Operations Transactions under the Transaction Type of Suspense Transactions detailed in the Contractor's cost proposal in Section C.3.5. Excess suspense transactions shall be determined when the number of suspended claims needing resolution exceeds an average of twelve thousand (12,000) per week for a twelve (12) week period. If the suspense inventory exceeds this total, then the Contractor shall be eligible for reimbursement of excess operations and/or excess staffing that will be needed to facilitate these transactions. Additionally, if in the event that policy changes or other external factors cause a decrease in the weekly suspense volumes, the Contractor may reduce staff or reallocate staff to support other functions with the approval of the State through a Control Memorandum. Data from TCMIS generated reports shall be utilized to monitor suspended and finalized volumes. The Contractor shall provide sufficient supporting documentation to obtain Bureau approval for reimbursement of the excess transaction costs as well as changes to staffing levels.

A.6.4.2.1. Provider and Suspense Processing Support Role:

a. Perform the Provider Customer Service activities
b. Perform Suspense resolution activities
c. Process Financial Transactions within the TCMIS
d. Process File Maintenance Transactions

A.6.4.3. Data Capture Services

The Data Capture team shall be staffed as follows:

Role	Number of Staff
Data Capture	21
QA Analyst	1
Data Capture Supervisor	1

A.6.4.3.1. Data Capture Role:

a. Perform, and validate Optical Character Recognition (OCR) and data-entry functions for claims and related inputs for all hard-copy claims and attachments.
b. Provide data capturing on correspondence that is received for indexing

199. Contract section A.6.5 is deleted in its entirety and replaced with the following:

A.6.5. Special Projects

A.6.5.1. Special Project Staffing

The staffing and budget for each Special Project shall be set forth in the Control Memorandum and Control Directive authorizing each Special Project, as set forth in Section C.3.4. Billing for Special Projects will reflect actual hours worked.

A.6.5.2. Special Project Determination

There shall be new projects that do not fall within normal change requests categories. These are typically large projects such as the recent Reform initiative where the level of effort is significant and the duration is extended. These projects shall not go through the normal change process and shall be staffed and managed through dedicated resources, using the billable rates as defined in Section C.3.4.

The Control Memorandum shall be the avenue to document the mutual agreement and designate a project as a Special Project, unless otherwise specified in section A.2 of this Contract. Once a project is designated as special, the Contractor shall coordinate with the Bureau to perform an estimate and procure the additional funding approval.

A.6.5.2.1. Special Project Criteria

The criteria for a Special Project are as follows:

a. The staff requirements are such that they cannot be performed using the existing staff or skill sets, or
b. The duration of the project is expected to extend beyond six (6) months, or
c. The number of resources is expected to be considerable (e.g., more than five (5) dedicated resources), or

d. The project is of such complexity that a dedicated Project Manager is required, or

e. A temporary increase of supplemental staff is needed to address a business need

A.6.5.3. Upcoming Special Projects

The Bureau shall advise the Contractor of any upcoming Special Project initiatives.

200. Contract section B.1 is deleted in its entirety and replaced with the following:

B.1. Contract Term

This Contract shall be effective for the period commencing on 07/01/2009 and ending on 06/30/2015. The State shall have no obligation for services rendered by the Contractor which are not performed within the specified period.

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

B.2. Term Extension

The State reserves the right to extend this Contract for an additional period or periods of time representing increments of no more than two one year options and a total contract term of no more than eight (8) years, provided that such an extension of the contract term is effected prior to the current, contract expiration date by means of an amendment to the Contract. If the extension of the Contract necessitates additional funding beyond that which was included in the original Contract, the increase in the State's maximum liability will also be affected through an amendment to the Contract, and shall be based upon payment rates provided for in the original Contract.

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

C.1. Maximum Liability

In no event shall the maximum liability of the State under this Contract exceed Two Hundred Fifty-Eight Million, Eight Hundred Fourteen Thousand Fifty-Four Dollars ($258,814,054.00). The payment rates in Section C.3 and the Travel Compensation provided in Section C.4. shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the payment rates detailed in Section C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

203. Contract section C.3 is deleted in its entirety and replaced with the following:

C.3. Payment Methodology

The Contractor shall be compensated based on the payment rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1.

a) The Contractor's compensation shall be contingent upon the satisfactory completion of units, milestones, or increments of service defined in Section A.

b) The Contractor shall be compensated for said units, milestones, or increments of service based upon the rates as defined in Section C.3.

c) Pass-Through Cost Payments—The Contractor shall submit a budget to the State of estimated pass-through services costs through a Control Memorandum for planning purposes, in advance of the fiscal period covered by the budget. The budget may be modified by Control Memorandum for any material changes in expected costs or changes to State approved vendors. The Bureau may prospectively direct a change to an approved pass through vendor through a Control Memorandum, allowing for sufficient time for transition from a prior vendor. The State shall reimburse the Contractor for pass-through costs on the basis of actual cost. Pass-through costs shall not include any overhead, administrative, or other fee or commission. The Contractor shall petition the State for a reimbursement of pass-through costs no more often than on a monthly basis, in addition to the regular invoice for professional services provided pursuant to this Contract. The petition for reimbursement of pass-through costs shall include substantiating documentation. Services reimbursed on a pass-through basis include postal related (i.e., postal services, postage and postal supplies); and third party vendor services (i.e., language translation, EDI support services, imaging/indexing/data capture system changes, call center system hardware maintenance support, TPAES support services and drug reference file). Costs for hardware, software and maintenance provided by approved third party vendors providing pass-through services will also be reimbursed on a pass-through basis.

Contractor shall make payment to the Bureau approved postal carrier (the US Postal Service) or the administrator of the Bureau postage meters (the US Postmaster and Pitney Bowes) on behalf of the Bureau; however, the Contractor shall have no responsibility for the delivery by the postal carrier to an addressee. Invoicing for postage meters shall be based on the funds paid to replenish the meter, less a credit for any Contractor postage in the prior period. Pass-through postage costs do not include Contractor postage for Contractor business operations. Contractor shall make payment to all other Bureau approved pass-through vendors on behalf of the Bureau; however, the Contractor shall have no responsibility for the quality and or performance of the services provided by these third party vendors. Approved pass-through vendors providing postal services and EDI support services shall be required to execute a Business Associate Agreement and commit to flow down provisions for HIPAA actual damages and breach liquidated damages added to the statements of work or purchase orders.

d) Professional Service Payments—The State shall compensate the Contractor based on the Service Rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1.

e) Special Projects Staffing compensation shall be based on the Payment Rates detailed in the Contractor's excess staffing proposal multiplied by the units of service authorized by the Bureau. The Bureau shall compensate the Contractor for Project work based on the hourly rates detailed Section C.3.4 or in the Contractor's excess staffing proposal, as approved by the Bureau. The Contractor shall submit monthly invoices, in form and substance agreed to with the Bureau with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall, at a minimum, include the name of each individual, the individual's job title, the number of hours worked during the period, the applicable Payment Rate,

the total compensation requested for the individual, and the total amount due the Contractor for the period invoiced.

Invoices for services with a pre-defined fixed block of hours shall, at a minimum, include the project name, the applicable block of hours for the services, the applicable Payment Rate, the total compensation requested for the services, and the total amount due the Contractor for the services invoiced. Such invoices shall be submitted for completed project or progress milestones as documented by Control Memorandum.

f) Hardware, Software and Maintenance – The State may request the Contractor purchase licenses or maintenance for hardware and software for the TCMIS, on behalf of the Bureau or the State of Tennessee, Department of Finance and Administration, Division of Health Care Finance and Administration. The State shall reimburse the Contractor for hardware and software products and maintenance purchased by request of the State based on the actual cost plus a seventeen percent (17%) gross margin on total actual costs up to two hundred thousand dollars ($200,000) and a thirteen percent (13%) gross margin on any additional actual cost. Invoiced amount is calculated as actual cost divided by one minus the gross margin [cost / (1 – margin)]. Hardware, software and maintenance includes but is not limited to the cost of the hardware or license, vendor deployment services and training, and annual maintenance, excluding such costs from approved pass through vendors as stated in C.3.c. The Contractor shall petition the State for a reimbursement of maintenance costs on a monthly, annual or other Bureau pre-approved basis, in addition to the regular invoice for professional services provided pursuant to this Contract, and any and all amendments thereto. The petition for reimbursement shall include substantiating documentation.

The Contractor shall submit invoices no more often than monthly, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment.

204. Contract section C.3.1 is deleted in its entirety and replaced with the following:

C.3.1. Assessment Pricing Details

The Contractor shall be compensated “per assessment/deliverable” during the Transition and Implementation Phase of this Contract. The Contractor shall be compensated in accordance with the fixed prices for each assessment/deliverable set forth in this Contract listed in the table labeled “Transition and Implementation Pricing Detail”. Total Transition and Implementation Fixed Prices shall factor in all related costs and overhead (e.g., Salaries & Benefits, Travel, and Administrative Overhead).

Assessment Pricing Detail Table follows:

Item #	Line Item Description	Fixed Price
1	Assessment 1 – MAR Assessment Section A.2.1.1	$142,881
2	Assessment 2 – ICD-10 Assessment Section A.2.1.2	See Below

ICD-10 Design (further defined in A.2.1.2) reimbursement shall be based on the Payment Rates detailed in C.3.4 Special Projects Staffing for units of service authorized by the State. The Contractor shall submit monthly invoices, in form and substance agreed to with the State with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall, at a minimum, include the name of each individual, the individual's job category, the number of hours worked during the period, the applicable Payment Rate, the total compensation requested for the individual, and the total amount due the Contractor for the period invoiced.

The maximum total fees for ICD-10 Design shall be one million one hundred thousand ninety eight thousand and nine hundred thirty eight dollars ($1,198,938.00). The Bureau may roll any residual funds that are unused for Phase 1 to ICD-10 Remediation (Phase 2) construction, configuration, testing and deployment activities.

205. Contract section C.3.2 is deleted in its entirety and replaced with the following:

C.3.2. Pricing of Major System Enhancements

The Contractor shall be compensated "per enhancement" to complete the TCMIS System Enhancements shown in the Request for Proposals. The Contractor shall be compensated in accordance with the fixed prices for each enhancement set forth in the Contract listed in the table labeled, Pricing of TCMIS System Enhancements. Total Enhancement Fixed Prices will already factor in all related costs and overhead (e.g., Salaries & Benefits, Travel, and Administrative Overhead).

Pricing of TCMIS System Enhancements

Item #	Line Item Description	*Fixed Price
E1	CMMI Level 2 Appraisal (Contract Section A.2.3)	
	Total Enhancement #1	$1,152,723
E1.1	CMMI Level 3 Appraisal (Contract Section A.2.3)	
	Total Enhancement #1.1	$1,353,196
E2	Technology Modernization (Contract Section A.2.4)	
	Total Enhancement #2	$4,681,343
E3	Implement PMO (Contract Section A.2.5)	
	Total Enhancement #3	$1,003,102
E4	Implement a COTS Dashboard (Contract Section A.2.6)	
	Total Enhancement #4	$553,840
E5	Implement a COTS Documentation software (Contract Section A.2.7)	
	Total Enhancement #5	$2,145,937
E6	Implement Enhanced Test Environment (Contract Section A.2.8)	
	Total Enhancement #6	$2,017,656
E7	Conduct Business Process Improvement (Contract Section A.2.9)	
	Total Enhancement #7	$2,530,716
E8	Implement Long-Term Care CHOICES (Contract Section A.2.10)	
	Total Enhancement #8	See Below
E9	Provider Portal Transfer (Contract Section A.2.11)	
	Total Enhancement #9	See Below
E10	SOA Factory Infrastructure (Contract Section A.2.12)	
	Total Enhancement #10	See Below

Enhancements #1 and #1.1 monthly invoices shall be in an amount equal to the maximum amount per enhancement detailed above divided by the number of calendar months in the subject period. The Bureau shall require retention of payment in the amount equal to fifteen percent (15%) of each monthly invoice for Enhancements #1 and #1.1. This retention of payment shall be held until the satisfaction of the final deliverable of the certification objective for that enhancement.

Enhancement #2 reimbursement shall be the maximum amount detailed above and allocated to the Bureau's acceptance of the following key deliverables, as follows.

1. Infrastructure Enhancements Installed (A.2.4.4.3 and A.2.4.4.4) = $2,955,125
2. Data Warehouse Enhancements Installed (A.2.4.4.5) = $1,631,763
3. Oracle Financial Transition Plan Accepted (A.2.4.4.6) = $17,870
4. Security Risk Assessment Accepted (A.2.4.4.7) = $ 76,585

Enhancement #3 reimbursement shall be made in lump sum on acceptance by the State of the base PMO standards, structures and staffing.

Enhancements # 4, #5 and #6 shall be made in lump sum upon acceptance by the State and implementation in production.

Enhancement #7 reimbursement shall be in an amount equal to the maximum amount for this enhancement detailed above divided by the number of MITA key business areas targeted by this enhancement, as referenced in A.2.9 and confirmed by the Bureau in the project planning process. Reimbursement for each business area shall be payable upon Bureau acceptance of the plan for the business processes, including mutually agreed upon process transformations and internal publication of the associated process documentation.

Enhancement #8 reimbursement shall be based on the Payment Rates detailed in C.3.4 Special Projects Staffing for units of service authorized by the State. The Contractor shall submit monthly invoices, in form and substance agreed to with the State with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall, at a minimum, include the name of each individual, the individual's job category, the number of hours worked during the period, the applicable Payment Rate, the total compensation requested for the individual, and the total amount due the Contractor for the period invoiced. The maximum total fees for Long-Term Care (LTC) CHOICES shall be one million nine hundred eighty six thousand two hundred fifty one dollars ($1,986,250.00). The Bureau may roll any residual funds that are unused for LTC CHOICES to ICD-10 Remediation (Phase 2) construction, configuration, testing and deployment activities.

Enhancement #9 reimbursements shall be based on the Payment Rates detailed in C.3.4 Special Projects Staffing for units of service authorized by the State. The Contractor shall submit monthly invoices, in form and substance agreed to with the State with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall, at a minimum, include the name of each individual, the individual's job family, the number of hours worked during the period, the applicable Payment Rate, the total compensation requested for the individual, and the total amount due the Contractor for the period invoiced. The maximum total fees for the Provider Portal shall be one million two hundred ninety one thousand nine hundred seventy dollars ($1,291,970.00). The Bureau may roll any residual funds that are unused for Provider Portal Transfer Enhancement 9 into the Special Project phase.

Enhancement #10 reimbursements shall be based on the Payment Rates detailed in C.3.4 Special Projects Staffing for units of service authorized by the State. The

Contractor shall submit monthly invoices, in form and substance agreed to with the State with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall, at a minimum, include the name of each individual, the individual's job family or job code level, the number of hours worked during the period, the applicable Payment Rate, the total compensation requested for the individual, and the total amount due the Contractor for the period invoiced. The maximum total fees for SOA Infrastructure shall be twelve million five hundred twenty thousand five hundred fourteen dollars ($12,520,514.00). The Bureau may roll any residual funds that are unused for SOA Infrastructure Enhancement 10 to Special Projects.

206. Contract section C.3.3 is deleted in its entirety and replaced with the following:

C.3.3. Operations Costs (TCMIS)

Pricing Schedule C1, Item #1 indicates the contracted base rate for operations of the TCMIS, excluding enhancements. Operations compensation shall be based on the Base Rate amounts detailed below for units of service authorized by the State. The Contractor shall submit monthly invoices, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Said monthly invoices shall be in an amount equal to the maximum amount per period detailed below divided by the number of calendar months in the subject period (the divisor shall be twelve (12) after the first period of service).

If, for any reason, the Contractor does not fully meet the operational start date for any of the TCMIS processes and a Contract amendment delaying this date or start-up of a portion of the processing requirements listed has not been approved, then the Contractor shall be liable for costs incurred by the Bureau to continue current operations. Additionally, the Contractor shall forfeit any claims to reimbursement of monthly operations payments for that month and each month thereafter until the Bureau approves operational readiness.

Pricing Schedule C2, Item #1 indicates the contracted incentive rate. The incentive payment shall be paid based on the quarterly performance report produced by the Performance Reporting System in accordance with Section B.1.1.

Pricing schedule C3, Items E1 – E7 shall indicate the contracted rates, if any, for the ongoing operational costs that may be expected for each of the enhancements.

Pricing Schedule C1
Operations Costs – Base Rate (TCMIS)

		Fixed Cost				
Item #	Line Item Description	Operational Year 1 (7/1/2009 – 06/30/2010)	Operational Year 2 (7/1/2010 – 06/30/2011)	Operational Year 3 (7/1/2011 – 06/30/2012)	Operational Year 4 (7/1/2012 – 06/30/2013)	Average
1	Base Rate	$22,270,718	$22,424,491	$23,029,219	$23,662,012	$22,846,610

Operations Costs – Base Rate (TCMIS)

		Fixed Cost			
Item #	Line Item Description	Operational Year 5 (7/1/2013 – 06/30/2014)	Operational Year 6 (7/1/2014 – 06/30/2015)	Optional Operational Year 7 (7/1/2015 – 06/30/2016)	Optional Operational Year 8 (7/1/2016 – 6/30/2017)
1	Base Rate	$30,645,000	$31,686,000	$32,636,580	$33,615,677

Pricing Schedule C2
Operations Costs – Incentive Rate (TCMIS)

		Fixed Cost				
Item #	Line Item Description	Operational Year 1 (7/1/2009 – 06/30/2010)	Operational Year 2 (7/1/2010 – 06/30/2011)	Operational Year 3 (7/1/2011 – 06/30/2012)	Operational Year 4 (7/1/2012 – 06/30/2013)	Average
1	Incentive Rate	$3,300,000	$3,300,000	$3,500,000	$3,500,000	$3,400,000

Operations Costs – Incentive Rate (TCMIS)

		Fixed Cost			
Item #	Line Item Description	Operational Year 5 (7/1/20013 – 06/30/2014)	Operational Year 6 (7/1/2014 – 06/30/2015)	Optional Operational Year 7 (7/1/2015 – 06/30/2016)	Optional Operational Year 8 (7/1/2016 – 6/30/2017)
1	Incentive Rate	$3,700,000	$3,800,000	$3,900,000	$4,000,000

Pricing Schedule C3
Operations Costs – Enhancement Operations (TCMIS)

		Fixed Cost			
Item #	Line Item Description	Operational Year 1 (7/1/2009 – 06/30/2010)	Operational Year 2 (7/1/2010 – 07/30/2011)	Operational Year 3 (7/1/2011 – 06/30/2012)	Operational Year 4 (7/1/2012 – 06/30/2013)
E1	Operations costs associated with maintaining CMMI Level 2 Appraisal	$0	$0	$0	$0
E1.1	Operations costs associated with maintaining CMMI Level 3 Appraisal	$0	$0	$0	$0
E2	Operations costs associated with Technology Modernization		$2,400,000	$2,472,000	$2,546,160
E3	Operations costs associated with PMO	$443,012	$547,563	$563,990	$580,909
E4	Operations costs associated with the COTS Dashboard	$0	$283,660	$292,169	$300,934
E5	Operations costs associated with the COTS Documentation software	$0	$30,258	$31,165	$32,100
E6	Operations costs associated with the Enhanced Test Environment	$21,409	$132,307	$136,276	$140,364
E7	Operations costs associated with Business Process Improvement	$0	$0	$158,190	$162,936
E8	Operations costs associated with LTC CHOICES	$0	$0	$0	$0

After Operational Year 4, the costs for Enhancement Operations are incorporated into the Operations Base Rate and are no longer invoiced separately.

207. Contract section C.3.4 is deleted in its entirety and replaced with the following:

C.3.4. Special Projects Staffing

Staffing for Special Projects (further defined in Contract Section A.6) compensation shall be based on the Payment Amounts detailed below for any staffing needs in excess of the contracted staffing levels, as authorized by the Bureau. The staffing and budget for each Special Project shall be set forth in the Control Memorandum and Control Directive authorizing each Special Project. The State shall compensate the Contractor for Change Order work based on the hourly rates below, in a total amount for each change request not to exceed the written estimate agreed upon by the State and the Contractor. The mutual agreement for an alternative rate shall be documented in the Control Memorandum authorization of work if a Special Project requires skills with a specialized technology or capability which is not anticipated in the tables below. The Contractor shall submit invoices no more often than monthly, in form and substance agreed to with the Bureau with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall be submitted for completed units of service for the amount stipulated.

NOTE: The Contractor shall not be compensated for travel time to the primary location of service provision, except as authorized in accordance with C.4 Travel Compensation.

CATEGORY	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE
	7/01/2009 - 6/30/2010	7/01/2010 - 6/30/2011	7/01/2011- 6/30/2012	7/01/2012 - 6/30/2013
Information Specialist – Senior	$103.56	$106.67	$109.87	$113.16
Information Specialist	$80.00	$82.40	$84.87	$87.42
Information Analyst	$57.14	$58.85	$60.62	$62.44
Information Associate	$52.08	$53.64	$55.25	$56.91
Business Services Analyst – Senior	$71.56	$73.71	$75.92	$78.20
Business Services Analyst – Advanced	$60.72	$62.54	$64.42	$66.35
Business Services Analyst	$55.00	$56.65	$58.35	$60.10
Technical Delivery Team Manager	$91.93	$94.69	$97.53	$100.45
Project Manager	$95.75	$98.62	$101.58	$104.63
Project Analyst – Senior	$85.00	$87.55	$90.18	$92.88
Project Analyst – Advanced	$75.00	$77.25	$79.57	$81.95
Project Analyst	$65.00	$66.95	$68.96	$71.03
Data Base Administrator	$83.75	$86.26	$88.85	$91.52
Data Base Associate	$68.26	$70.31	$72.42	$74.59
Infrastructure Specialist Senior	$96.53	$99.43	$102.41	$105.48
Systems Administrator - - Advanced	$68.26	$70.31	$72.42	$74.59
Systems Administrator	$56.82	$58.52	$60.28	$62.09
Systems Administrator - Associate	$50.00	$51.50	$53.05	$54.64
Computer Operator	$35.00	$36.05	$37.13	$38.25
QA Specialist - Advanced	$70.00	$72.10	$74.26	$76.49
QA Specialist	$55.00	$56.65	$58.35	$60.10

CATEGORY	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE
	7/01/2009 - 6/30/2010	7/01/2010 - 6/30/2011	7/01/2011- 6/30/2012	7/01/2012 - 6/30/2013
Documentation Project Manager	$70.00	$72.10	$74.26	$76.49
Technical Writer	$45.00	$46.35	$47.74	$49.17
Specialized Support Clerk	$35.00	$36.05	$37.13	$38.25
General Support Clerk	$20.00	$20.60	$21.22	$21.85
Change Management Coordinator	$65.00	$66.95	$68.96	$71.03
Release Coordinator	$65.00	$66.95	$68.96	$71.03
Work Planner	$65.00	$66.95	$68.96	$71.03

Standard Rates JOB FAMILY	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE
	7/01/2013 - 6/30/2014	7/01/2014 - 6/30/2015	**Optional** 7/01/2015- 6/30/2016	**Optional** 7/01/2016– 6/30/2017
Architect	$112.28	$115.65	$119.12	$122.70
Developer	$98.46	$101.42	$104.46	$107.59
Business Analyst	$75.24	$77.50	$79.82	$82.22
Project Manager	$107.77	$111.00	$114.33	$117.76
Data Base Administrator	$97.95	$100.89	$103.92	$107.03
Systems Administrator	$79.96	$82.35	$84.82	$87.37
IT Operations Specialist	$56.81	$58.51	$60.27	$62.08
Quality	$86.21	$88.80	$91.46	$94.21

Specialized Rates JOB CODE LEVEL	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE
	Amendment 1 effective date - 6/30/2013	7/01/2013 - 6/30/2014	7/01/2014 - 6/30/2015	**Optional** 7/01/2015- 6/30/2016	**Optional** 7/01/2016- 6/30/2017
I – Entry	$67.22	$69.24	$71.31	$73.45	$75.66
II – Intermediate	$92.61	$95.39	$98.25	$101.20	$104.24
III – Specialist	$122.10	$125.76	$129.53	$133.42	$137.42
IV – Expert	$143.84	$148.16	$152.60	$157.18	$161.90
V – Master	$177.70	$183.03	$188.52	$194.18	$200.00
Manager	$191.55	$197.30	$203.21	$209.31	$215.59

Specialized rates apply for more specialized technology skills, such as but not limited to Service Oriented Architecture, Rational, Oracle, FileNet, Exstream, and Siebel. Standard rates apply for standard technology skills, such as but not limited to C, PowerBuilder and ASP.NET.

208. Contract section C.3.5 is deleted in its entirety and replaced with the following:

C.3.5. Excess Operations Transactions

Excess Operations Transactions compensation shall be based on the Payment Amounts detailed below for any transaction units in excess of the contracted requirement, as authorized by the Bureau. The Contractor shall submit invoices no more often than quarterly in form and substance agreed to with the State with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall be submitted for completed units of service for the amount stipulated.

TRANSACTION TYPE	FIXED FEE PER TRANSACTION			
	07/01/2009 06/30/2010	07/01/2010 – 06/30/2011	07/01/2011 – 06/30/2012	07/01/2012 – 06/30/2013
Suspense Transactions	$0.88	$0.88	$0.89	$0.89

TRANSACTION TYPE	FIXED FEE PER TRANSACTION			
	07/01/2013 - 06/30/2014	07/01/2014 – 06/30/2015	Optional 07/01/2015 – 06/30/2016	Optional 07/01/2016 – 06/30/2017
Suspense Transactions	$0.90	$0.90	$0.91	$0.91

Note:

Excess Suspense Transactions is defined as suspended claims needing resolution activities. Excess suspense transactions shall be determined when the number of suspended claims needing resolution exceeds an average of twelve thousand (12,000) per week for a twelve (12) week period. If the suspense inventory exceeds this total, then the Contractor shall be eligible for reimbursement of excess operations per claim and/or excess staffing that will be needed to facilitate these transactions. Additionally, if in the event that policy changes or other external factors cause a decrease in the weekly suspense volumes, the contractor shall reduce staff or reallocate staff to support other functions. Data from TCMIS generated reports shall be utilized to monitor suspended and finalized volumes. The Contractor shall provide sufficient supporting documentation to obtain Bureau approval for reimbursement of the excess transaction costs as well as changes to staffing levels.

209. Contract section E.2 is deleted in its entirety and replaced with the following:

E.2 Communications and Contacts

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

The State:
Deputy Commissioner
Department of Finance and Administration

Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243
Telephone # (615) 507-6443
FAX # (615) 741-0882
Darin.j.gordon@tn.gov

The Contractor:
Account Executive
HP Enterprise Services TennCare
310 Great Circle Road
Nashville, TN 37228
Telephone # (615) 507-6124
dennis.vaughan@hp.com

Copy to:
HP Legal
5400 Legacy Drive
Mail Stop H3-3A-01
Plano, TX 75024
Telephone #(972) 605-5484

All instructions, notices, consents, demands, or other communications shall be considered effectively given upon receipt or recipient confirmation as may be required. See Attachment C: Business Associate Agreement for additional notifications regarding privacy and security events.

210. Contract section E.6 is deleted in its entirety and replaced with the following:

E.6. Breach

A party shall be deemed to have breached the Contract if any of the following occurs:

— failure to perform in accordance with any term or provision of the Contract;
— partial performance of any term or provision of the Contract;
— any act prohibited or restricted by the Contract, or
— violation of any warranty.

For purposes of this Contract, these items shall hereinafter be referred to as a "Breach."

a. Contractor Breach— The State shall notify Contractor in writing of a Breach.

(1) In event of a Breach by Contractor, the State shall have available the remedy of Actual Damages and any other remedy available at law or equity.

(2) Liquidated Damages— In the event of a Breach, the State may assess Liquidated Damages. The State shall notify the Contractor of amounts to be assessed as Liquidated Damages. The parties agree that due to the complicated nature of the Contractor's obligations under this Contract it would be difficult to specifically designate a monetary amount for a Breach by Contractor as said amounts are likely to be uncertain and not easily proven. Contractor hereby represents and covenants it has carefully reviewed the Liquidated Damages contained in Attachment B and agree that said amounts represent a reasonable relationship between the amount and what might reasonably be expected in the event of Breach, and are a reasonable estimate of the damages that would occur from a Breach. It is hereby agreed between the parties that the Liquidated Damages represent solely the damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party. The Contractor agrees that the liquidated damage amount is in addition to any

amounts Contractor may owe the State pursuant to the indemnity provision or other section of this Contract.

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

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

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

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

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

b. State Breach— In the event of a Breach of Contract by the State, the Contractor shall notify the State in writing within thirty (30) days of any Breach of Contract by the State. Said notice shall contain a description of the Breach. Failure by the Contractor to provide said written notice shall operate as an absolute waiver by the Contractor of the State's Breach. In addition to any other provisions in this Agreement, Contractor's nonperformance of its obligations under this Agreement will be excused if and to the extent (a) such Contractor nonperformance results from State's failure to perform its responsibilities (or cause them to be performed) and (b) Contractor provides State with

reasonable notice of such nonperformance and uses commercially reasonable efforts to perform notwithstanding State's failure to perform. In the event of Breach by the State, the Contractor may avail itself of any remedy at law in the forum with appropriate jurisdiction; provided, however, failure by the Contractor to give the State written notice and opportunity to cure as described herein operates as a waiver of the State's Breach. Failure by the Contractor to file a claim before the appropriate forum in Tennessee with jurisdiction to hear such claim within one (1) year of the written notice of Breach shall operate as a waiver of said claim in its entirety. It is agreed by the parties this provision establishes a contractual period of limitations for any claim brought by the Contractor.

211. Contract section E.11 is deleted in its entirety and replaced with the following:

E.11 Disputes

The Parties agree that any dispute(s) arising out of this Contract that is/are brought forward by Contractor, shall first be addressed by the good faith reasonable efforts of the parties, including use of the Control Memorandum Process pursuant to Section A.1 of this Contract, to resolve such dispute(s) through mutual agreement prior to the submission of a claim. The Parties agree that the appeal steps set forth in the Control Memorandum Process in Section A.1 are the sole method of appeal for the specific disputes described therein, including, but not limited to, Liquidated Damage assessments, and no further appeal or claim may be filed under the process stated below in the second paragraph of this Section E.11.

If the above endeavors fail to resolve the dispute(s), any claim by the Contractor against TennCare arising out of the breach of this Contract shall be handled in accordance with the provision of Tennessee Code Annotated § 9-8-301, et seq., provided, however, that Contractor agrees that it shall give notice to TennCare of its claim thirty (30) calendar days prior to filing the claim in accordance with Tennessee Code Annotated § 9-8-301, et seq. **Notwithstanding the foregoing, TennCare reserves the right, at its sole discretion, to utilize non-binding dispute resolution or mediation services to resolve issues in controversy.**

If the endeavors described in last sentence of the second paragraph of this subsection are attempted and fail to resolve the dispute(s), or should TennCare choose to not exercise its right to first attempt to resolve any dispute(s) by said endeavors, any claim by TennCare against the Contractor shall follow the procedures outlined in Sections D and E relating to Breach and Termination and/or Attachment B, Liquidated Damages.

212. Contract section E.19 is deleted in its entirety and replaced with the following:

E.19. Confidentiality of Records

Strict standards of confidentiality of records shall be maintained in accordance with the State and federal law, regulations and court orders. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of State and federal law and ethical standards and shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with State and federal law and ethical standards.

The Contractor will be deemed to have satisfied its obligations under this section by exercising the same level of care to preserve the confidentiality of the State's information as the Contractor exercises to protect its own similar confidential information so long as such standard of care does not violate the applicable provisions of the first paragraph of this section.

The Contractor's obligations under this section do not apply to information in the public

domain; entering the public domain but not from a breach by the Contractor of this Contract; previously possessed by the Contractor without written obligations to the State to protect it; acquired by the Contractor without written restrictions against disclosure from a third party which, to the Contractor's knowledge, is free to disclose the information; independently developed by the Contractor without the use of the State's information; or, disclosed by the State to others without restrictions against disclosure.

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

213. Contract section E.26 is deleted in its entirety and replaced with the following:

E.26 HIPAA and HITECH Compliance

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

Contractor warrants to the State that it is familiar with the requirements of HIPAA and HITECH and their accompanying regulations, and shall comply with all applicable HIPAA and HITECH requirements in the course of this Contract including but not limited to the following:

1. Compliance with the Privacy Rule, Security Rule, Notification Rule;
2. The creation of and adherence to sufficient Privacy and Security Safeguards and Policies;
3. Timely Reporting of Violations in the Access, Use and Disclosure of PHI; and
4. Timely Reporting of Privacy and/or Security Incidents.

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

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

E.26.1 **As a party to this Contract, the Contractor hereby acknowledges its designation as a covered entity and/or business associate under the HIPAA regulations and agrees to comply with all applicable HIPAA and HITECH (hereinafter "HIPAA/HITECH") regulations. In accordance with HIPAA/HITECH regulations, the Contractor shall, at a minimum:**

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

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

c. Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA/HITECH standards, that

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

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

e. Report to TennCare's Privacy Office immediately upon becoming aware of any use or disclosure of PHI in violation of this Contract by the Contractor, its officers, directors, employees, subcontractors or agents or by a third party to which the Contractor disclosed PHI;

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

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

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

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

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

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

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

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

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

o. Create and implement policies and procedures to address present and future HIPAA/HITECH regulatory requirements as needed, including, but not limited to: use and disclosure of data; de-identification of data; minimum necessary access; accounting of disclosures; enrollee's right to amend, access, request restrictions; notice of privacy practices and right to file a complaint;

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

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

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

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

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

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

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

w. Make available PHI in accordance with 45 C.F.R. § 164.524;

x. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526; and

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

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

214. Contract section E.27 is deleted in its entirety and replaced with the following:

E.27 HITECH Compliance

All references in this Contract to this Section E.27 HITECH Compliance shall be deemed to be references to Section E.26 HIPAA and HITECH Compliance and shall be construed using the provisions and requirements of Section E.26.

215. Contract section E.28 is deleted in its entirety and replaced with the following:

E.28 Tennessee Bureau of Investigation (TBI) Medicaid Fraud and Abuse Unit (MFCU),

TennCare Office of Program Integrity and Office of TennCare Inspector General (OIG) and General Access to Contractor Records

a) Enrollee Records-Consent. As a condition of participation in TennCare, enrollees have given TennCare, the Office of the Comptroller of the Treasury, and any health oversight agency, such as Office of the Inspector General (OIG), Tennessee Bureau of Investigation Medicaid Fraud and Abuse Unit (TBI MFCU), Department of Health and Human Services Office of Inspector General (DHHS OIG), and Department of Justice (DOJ) , and any other authorized state or federal agency, access to their records. The Contractor shall make available said records and furnish immediately upon request by the Contractor for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the Contractor, TennCare or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCU, the DHHS OIG and the DOJ.

b) TennCare Records-Access. The Contractor agrees that as a condition of payment under this contract TennCare, DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Contract including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. In addition, the TBI MFCU/OIG/TennCare Office of Program Integrity shall be allowed access to the place of business and to all TennCare records of any contractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCU/OIG/TennCare Office of Program Integrity. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, TBI MFCU, DHHS OIG and DOJ. Any authorized state or federal agency or entity, including, but not limited to TennCare, the Office of the Inspector General (OIG), TBI MFCU, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, may use these records and information for administrative, civil or criminal investigations and prosecutions.

c) Records Retention. A TennCare record is any record, in whatever form, including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution The Contractor, as well as its subcontractors, shall maintain TennCare records necessary to demonstrate that covered services were provided in compliance with state and federal requirements. An adequate record system shall be maintained and that all records be maintained for five (5) years from the close of the provider agreement (behavioral health records shall be maintained at the provider level for ten (10) years after the termination of service pursuant to TCA 33-3-101) or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the provider agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions).

E.28.1 Prevention/Detection of Provider Fraud and Abuse

The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities.

E.28.2 Fraud and Abuse Compliance Plan

The Contractor shall have a written Fraud and Abuse compliance plan and initiate appropriate internal controls. A paper and electronic copy of the plan shall be provided to the State Office of the Inspector General. The Contractor's specific internal controls and policies and procedures shall be described in a comprehensive written plan and be maintained on file with the Contractor for review and approval by the State Office of the Inspector General by the Modified Operation Start Date of this Agreement. The State Office of the Inspector General shall provide notice of approval, denial, or modification to the Contractor within thirty (30) days of review. The Contractor shall make any requested updates or modifications available for review to TennCare and/or the State Office of the Inspector General as requested by TennCare and/or the State Office of the Inspector General within thirty (30) days of a request. The State shall not transfer their law enforcement functions to the Contractor. At a minimum the written plan shall:

i. Ensure that all managers and employees know and understand the provisions of the Contractor's fraud and abuse compliance plan;

ii. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract:

iii. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and fraud, such as Claims edits;

iv. Contain provisions for the confidential reporting of suspect plan violations to the designated person as described in item E.28.3 below;

v. Contain provisions for the investigation and follow-up of any compliance plan reports;

vi. Ensure that the identities of individuals reporting violations of the plan are protected;

viii. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU (Medicaid Fraud Control Unit) and that enrollee fraud and abuse be reported to the State Office of the Inspector General;

ix. Ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.

E.28.3 Fraud and Abuse Compliance Officer

The Contractor shall designate an owner in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.

E.28.4. Annual Report to OIG

The Contractor shall submit an annual report to the State Office of the Inspector General that includes summary results of fraud and abuse tests performed as required by E.28.2.iii and detailed in the Contractor's Fraud and Abuse compliance plan. The report should cover results for the year ending June 30 and be submitted by September 30 each year. This information in this report shall be provided in accordance with and in a format as described in the Contractor's approved compliance plan.

216. The following is added as Contract section E.36:

E.36 Information Holders

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

217. The following is added as Contract section E.37:

E.37 Notification of Breach and Notification of Provisional Breach

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

218. The following is added as Contract section E.38:

E.38 Social Security Administration (SSA) Required Provisions for Data Security

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

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

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

c) The Contractor shall provide a current list of the employees of such contractor with access to SSA data and provide such lists to TennCare upon request.

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

e) The Contractor shall ensure that its employees:

1) properly safeguard PHI/PII furnished by TennCare under this Contract from loss, theft or inadvertent disclosure;
2) understand that they are responsible for safeguarding this information at all times, regardless of whether or not the Contractor employee is at his or her regular duty station;
3) ensure that laptops and other electronic devices/ media containing PHI/PII are encrypted and/or password protected;
4) send emails containing PHI/PII only if encrypted or if to and from addresses that are secure; and,
5) limit disclosure of the information and details relating to a PHI/PII loss only to those with a need to know.

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

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

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

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

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

i) Definitions – The following definitions shall apply to this Contract with regard to the Social Security Administration:

1) "SSA-supplied data" – information, such as an individual's social security number, supplied by the Social Security Administration to TennCare to determine entitlement or eligibility for federally-funded programs (CMPPA between SSA and F&A; IEA between SSA and TennCare).
2) "Protected Health Information/Personally Identifiable Information" (PHI/PII) (45 C.F.R. § 160.103; OMB Circular M-06-19) – Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.
3) "Individually Identifiable Health Information" – information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii)

with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

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

219. The following is added as Contract section E.39:

E.39 Contractor Commitment to Diversity

The Contractor shall comply with and make reasonable business efforts to exceed the commitment to diversity as required by federal and State law.

The Contractor shall assist the State in monitoring the Contractor's performance of this commitment by providing, as requested, a quarterly report of participation in the performance of this Contract by small business enterprises and businesses owned by minorities, women, and persons with a disability. Such reports shall be provided to the State of Tennessee Governor's Office of Business Diversity Enterprise in form and substance as required by said office.

220. The following is added as Contract section E.40:

E.40 Applicable Laws, Rules and Policies

Contractor agrees to comply with all applicable federal and State laws, rules, regulations and executive orders, including, but not limited to, Constitutional provisions regarding due process and equal protection of the laws.

221. The following is added as Contract section E.41:

E.41 Employees Excluded from Medicare, Medicaid or CHIP

The Contractor does hereby attest, certify, warrant, and assure that the Contractor shall not employ, in the performance of this Contract, employees who have been excluded or terminated from participation in the Medicare, Medicaid, and/or CHIP programs pursuant to Sections 1128 of the Social Security Act. The Contractor shall perform monthly checks of its employees to ensure that they have not been added to the various excluded individual databases maintained by the Federal Government. The Contractor further attests that no individual or entity with a 5% or greater ownership interest has been excluded or terminated from participation in Medicare, Medicaid, and/or CHIP programs.

222. The following is added as Contract section E.42:

E.42 Federal Funding Accountability and Transparency Act (FFATA)

This Contract requires the Contractor to provide supplies and/or services that are funded in whole or in part by federal funds that are subject to FFATA. The Contractor is responsible for ensuring that all applicable requirements, including but not limited to those set forth herein, of FFATA are met and that the Contractor provides information to the State as required.

The Contractor shall comply with the following:

a. Reporting of Total Compensation of the Contractor's Executives.

1) The Contractor shall report the names and total compensation of each of its five most highly compensated executives for the Contractor's preceding completed fiscal year, if in the Contractor's preceding fiscal year it received:

i. 80 percent or more of the Contractor's annual gross revenues from Federal procurement contracts and Federal financial assistance subject to the Transparency Act, as defined at 2 C.F.R. 170.320 (and subawards); and
ii. $25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts), and Federal financial assistance subject to the Transparency Act (and subawards); and
iii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at http://www.sec.gov/answers/execomp.htm.).

Executive means officers, managing partners, or any other employees in management positions.

2) Total compensation means the cash and noncash dollar value earned by the executive during the Contractor's preceding fiscal year and includes the following (for more information see 17 C.F.R. § 229.402(c)(2)):

i. Salary and bonus.
ii. Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.
iii. Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.
iv. Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.
v. Above-market earnings on deferred compensation which is not tax qualified.
vi. Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds $10,000.

b. The Contractor must report executive total compensation described above to the State by the end of the month during which this Contract is awarded.

c. If this Contract is amended to extend its term, the Contractor must submit an executive total compensation report to the State by the end of the month in which the amendment to this Contract becomes effective.

d. The Contractor will obtain a Data Universal Numbering System (DUNS) number and maintain its DUNS number for the term of this Contract. More information about obtaining a DUNS Number can be found at: http://fedgov.dnb.com/webform/

The Contractor's failure to comply with the above requirements is a material breach of this Contract for which the State may terminate this Contract for cause. The State will not be obligated to pay any outstanding invoice received from the Contractor unless and until the Contractor is in full compliance with the above requirements.

223. The following is added as Contract section E.43:

E.43 Medicaid and CHIP – Safeguards

The Contractor must provide safeguards that restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan:

a. Purposes directly related to the administration of Medicaid and CHIP include:

1) Establishing eligibility;
2) Determining the amount of medical assistance;
3) Providing services for beneficiaries; and,
4) Conducting or assisting an investigation, prosecution, or civil or criminal
5) proceeding related to Medicaid or CHIP administration.

b. The Contractor must have adequate safeguards to assure that:

1) Information is made available only to the extent necessary to assist in the valid administrative purposes of those receiving the information, and information received under 26 USC section 6103(l) is exchanged only with parties authorized to receive that information under that section of the Code; and,
2) The information is adequately stored and processed so that it is protected against unauthorized disclosure for other purposes.

c. The Contractor must have criteria that govern the types of information about applicants and beneficiaries that are safeguarded. This information must include at least:

1) Names and addresses;
2) Medical services provided;
3) Social and economic conditions or circumstances;
4) Contractor evaluation of personal information;
5) Medical data, including diagnosis and past history of disease or disability; and
6) Any information received for verifying income eligibility and amount of medical assistance payments, including income information received from SSA or the Internal Revenue Service,
7) Any information received for verifying income eligibility and amount of medical assistance payments
8) Income information received from SSA or the Internal Revenue Service must be safeguarded according to Medicaid and CHIP requirements
9) Any information received in connection with the identification of legally liable third party resources
10) Social Security Numbers.

d. The Contractor must have criteria approved by the State specifying

1) The conditions for release and use of information about applicants and beneficiaries:
2) Access to information concerning applicants or beneficiaries must be restricted to persons or Contractor representatives who are subject to standards of confidentiality that are comparable to those of the State.
3) The Contractor shall not publish names of applicants or beneficiaries.

4) The Contractor shall obtain permission from a family or individual, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of medical assistance payment to an authorized individual or entity;

5) If, because of an emergency situation, time does not permit obtaining consent before release, the Contractor shall notify the State, the family or individual immediately after supplying the information.

6) The Contractor's policies must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials.

   i. The Contractor shall notify the State of any requests for information on applicants or beneficiaries by other governmental bodies, the courts or law enforcement officials ten (10) days prior to releasing the requested information.

7) If a court issues a subpoena for a case record or for any Contractor representative to testify concerning an applicant or beneficiary, the Contractor must notify the State at least ten (10) days prior to the required production date so the State may inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information, effective until Jan. 1, 2014.

8) The Contractor shall not request or release information to other parties to verify income, eligibility and the amount of assistance under Medicaid or CHIP, prior to express approval from the State.

224. Contract Attachment B, Incentives and Liquidated Damages, is deleted in its entirety and replaced with the new attachment, Revised Attachment B, Incentives and Liquidated Damages, attached hereto.

225. Contract Attachment C, HIPAA Business Associate Agreement, is deleted in its entirety and replaced with the new attachment, Revised Attachment C, HIPAA Business Associate Agreement, attached hereto.

226. Contract Attachment D, Glossary, is deleted in its entirety and replaced with the new attachment, Revised Attachment D, Glossary, attached hereto.

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

Amendment Effective Date. The revisions set forth herein shall be effective June 1, 2013. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

HP ENTERPRISE SERVICES, L.L.C.:

SIGNATURE **DATE**

PRINTED NAME AND TITLE OF SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE:

MARK A. EMKES, COMMISSIONER **DATE**

Attachment B Incentives and Liquidated Damages

Contractor Incentives and Liquidated Damages

B.1 Contractor Incentive - Performance-Based Contract and Damages

To effectively manage contractual performance, the Bureau has established measures to evaluate the Contractor's obligations with respect to the requirements. The Contractor is expected to perform according to a certain level of standards. If these standards are not met, the State is entitled to impose damage assessment stratagems and institute dispute resolutions. If the Contractor surpasses performance standards they may be entitled to an incentive payment, as documented in the Performance Reporting System. These measures are meant to support all activities required to operate and enhance the TCMIS infrastructure.

B.1.1 Contractor Incentive - Performance Management and Measures

The Contractor shall be measured in all of the business functional areas for quality system and operational performance, based upon criteria as agreed by the Bureau and the Contractor.

These criteria shall:

Improve the quality of Contractor performance;
Provide documented performance levels in all critical areas of the system;
Improve the management of the Contractor's Contract; and
Improve the State and federal government return on investment for administration of the TennCare program.

The Bureau shall identify areas of Contractor performance where quality is critical to the mission of the TennCare Program.

During Transition, the Bureau shall reach agreement with the Contractor concerning the critical areas of performance, performance standards, and levels of quality that are desirable, acceptable and substandard. These standards shall be documented in a Performance Reporting plan, which shall be incorporated into the Performance Reporting System. The evaluation of performance shall occur quarterly, beginning during the first State Fiscal quarter after the Performance Reporting System is operational. The agreement concerning critical areas of performance, performance standards, and levels of quality, between the Contractor and the Bureau, shall be reached ninety (90) days prior to the Modified Operations Start Date. If an agreement is not reached during this time, the incentives shall not take effect on the start of operations. Additionally, the annual incentive shall be decreased by one-fourth (1/4) for any quarter when the incentive is not effective at the beginning of the quarter. The effective date of the incentive shall be the later of the start of operations or ninety (90) days after the agreement between the Bureau and the Contractor concerning critical areas of performance, performance standards, and levels of quality. The agreement shall be memorialized in an official correspondence that shall be available to the Department of General Services, Central Procurement Office, and to the Comptroller of the Treasury, upon request.

The Contractor shall develop and/or install a Performance Reporting System as a means to measure performance levels on a quarterly basis. The Contractor shall provide the quarterly performance report produced by the Performance Reporting System in a manner acceptable to the Bureau, on or before the last business day of the month following the reporting quarter.

B.1.2 Approach to Performance Standards and Damages

B.1.2.1.The Bureau shall identify areas of Contractor performance where quality is critical to the mission of the TennCare Program.

B.1.2.2. During Start-up, the Bureau shall reach agreement with the Contractor concerning the critical areas of performance, performance standards, and levels of quality that are desirable, acceptable and substandard for each area, as outlined in B.1.1.

B.1.2.3. The Contractor shall provide an automated method for TCMIS and other system/operations tools used to provide the monthly reports of the quality measurements agreed upon by the Bureau and the Contractor at no additional programming cost to the Bureau.

B.1.2.4. The automated reports shall be flexible and adaptable to changes in the quality measurements as agreed upon by the Bureau and Contractor..At no time during the performance of this Contract shall Liquidated Damages be assessed against Contractor for failure to deliver a report, log or other compliance indicator before these tools have been created and approved by the Bureau.

B.1.2.5. During the term of the Contract, the Contractor shall measure performance using the Performance Reporting System. All information used to calculate the performance metrics shall be stored in tables or databases and accessed through the dashboard software required in the TCMIS enhancement listed in Section A.2.6. Supporting documentation shall be maintained by the Contractor for all performance metric calculations. The supporting documentation for any performance metric shall be delivered to the Bureau within two (2) business days after it is requested. Bureau Contract Management staff shall actively participate with the Contractor in the performance reporting process and shall approve the results recorded.

B.1.2.6. Critical areas of performance, performance standards, levels of quality, and the associated measurements shall be reviewed by the Bureau and the Contractor on an annual basis (or as otherwise directed by the Bureau) to assess any critical areas of performance, performance standards, levels of quality, or any associated measurements that should be changed, added or deleted for the next reporting period. The review of the critical areas of performance, performance standards, levels of quality and associated measurements shall be completed and agreed upon prior to the beginning of the subsequent year, unless a different interval of time is specified by the Bureau. If an agreement is not reached prior to the beginning of the subsequent year or other specified interval of time, the incentive updates shall not be effective until the quarter following agreement. These agreements will be incorporated into the Performance Reporting System. The agreement shall be memorialized in an official correspondence that shall be available to the Department of General Services, Central Procurement Office, and to the Comptroller of the Treasury, upon request.

B.1.2.7. At the end of each reporting period, the Performance Reporting System results shall be posted on the TennCare intranet by the agreed publication date.

B.1.2.8. Intentionally Left Blank.

B.1.2.9. Each performance measure shall have its own scoring mechanism established through negotiation with the Contractor and the Bureau and shall consist of a tiered scoring methodology and participation levels.

B.1.3 Right to Assess Damages

As permitted under this Contract and in conformity with the provisions of Section A.1 regarding the Control Memorandum process, the Bureau may assess damages based on evaluations of the Contractor's success in meeting required performance standards by the Bureau Contract Administrator. The Contractor may accept the damages assessed by the Bureau or challenge the reimbursement to the Bureau for actual damages or the amounts set forth as liquidated damages.

If the Contractor disagrees with the damage assessment, the following resolution steps shall be followed:

1) Contractor management may first discuss the issues verbally with Bureau management.

2) Contractor management may submit a written document to propose a corrective action plan to remedy the deficiency. The Bureau reserves the right in its sole discretion to grant the Contractor the opportunity to cure deficient performance by means of a Corrective Action Plan (CAP). Contractor's failure to meet the terms of the CAP may result in the assessment of damages.

3) The Bureau may elect to present the issue to the Director of TennCare and ask that s/he meet with Contractor management for issues resolution or damage assessment.

4) If damages can be measured in actual cost, they shall be referred to as actual damages. If the damages are difficult to measure or cannot be measured in actual cost, they shall be referred to as liquidated damages.

5) The Bureau shall notify the Contractor in writing of the proposed damage assessment. The amounts due the Bureau as actual damages may be deducted from any fees or other compensation payable to the Contractor, or the Bureau may require the Contractor to remit the damages within thirty (30) days following the notice of assessment or resolution of any dispute. At the Bureau's option, the Bureau may obtain payment of assessed actual damages through one (1) or more claims upon any performance bond furnished by the Contractor.

B.1.4 Actual and Liquidated Damages

Damage may be sustained by the Bureau in the event that the Contractor fails to meet the requirements of this Contract. As permitted under this Contract and in conformity with the provisions of Section A.1 regarding the Control Memorandum process, in the event of default or the inability to maintain minimum requirements or standards as determined by the Bureau, the Contractor agrees to pay the Bureau for the actual cost of damages or the specifically outlined sums as liquidated damages. The maximum amount of Liquidated Damages payable over any twelve (12) month period shall not exceed 20 percent of the annual fixed price billings. In the event that a single occurrence subjects the Contractor to Liquidated Damages in multiple subsections of this provision, the State is entitled to assess a single Liquidated Damage selected as the discretion of the State. Liquidated Damages shall not be assessed if the delay or failure to timely perform its obligations is caused by factors beyond the reasonable control and without any material error or negligence of the Contractor, its staff or subcontractors. Liquidated damages are considered compensation for increased Contract management and do not constitute a penalty.

The list of Compliance Performance Metrics and associated Liquidated Damages are included in this Attachment. Liquidated and actual damages may be assessed for performance measures that are not resolved based on the Contractor's corrective action plan.

B.1.5 Dispute Resolution Process for Damage Assessments

The Bureau expects that any disputes arising under this Contract shall be approached first through negotiations with the Bureau's Contract Manager and second through negotiation with the Deputy Commissioner of Finance and Administration, Bureau of TennCare, as set forth in Section A.1 of this Contract through use of the Control Memorandum process. Legal action should only be initiated if all of these mechanisms fail.

Notwithstanding the foregoing, TennCare reserves the right, at its sole discretion, to utilize non-binding dispute resolution or mediation services to resolve issues in controversy.

Regardless of whether or not informal negotiation, non-binding mediation or legal action is used to resolve the dispute, the State may make a claim against the Performance Bond required under this contract after a third party has given an opinion on the merits of the dispute, either through mediation or a court proceeding, or after two years, whichever comes first. See Section E.11.

Venue for any disputes shall be in Nashville, Tennessee. In any such review, the Contractor shall have the burden to prove the decision of the Bureau's Contract Manager to be incorrect. Pending final

determination of any dispute, the Contractor shall proceed diligently with performance of the Contract and in accordance with the direction of the Bureau's Contract Manager.

B.2 Actual Damages

As permitted under this Contract and in conformity with the provisions of Section A.1 regarding the Control Memorandum process, the Bureau may assess actual damages. Amounts due the Bureau as actual damages may be deducted by the Bureau from any money payable to the Contractor pursuant to this Contract. The Bureau shall notify the Contractor through a Control Memorandum and Control Directive on or before the date the Bureau deducts such sums from money payable to the Contractor. Actual damages are assessed only for errors due to omissions or negligence of the Contractor.

Contractor shall be responsible for timeliness of Claims Processing, such that the aggregate fee-for-service claims timeliness are within the prompt pay standards set by CMS. For aggregate fee-for-service claims the standards are:

1) Ninety Percent (90%) of all clean claims shall be paid or denied within thirty (30) days of receipt; and

2) Ninety-nine Percent (99%) of all clean claims shall be paid or denied within ninety (90) days of receipt.

The damage that may be assessed shall be the resulting loss in federal match for the payments processed by the Contractor. Contractor shall not be liable to the extent the non-compliance with Prompt Pay is caused by the Bureau or another fee-for-service processing designee of the Bureau.

Contractor shall be liable for the actual amount of claims overpayments caused by Contractor, that are not recovered by the Bureau within sixty (60) days using available remedies for recoupment or recovery, unless the Bureau has written-off the provider receivable. Contractor may pursue recovery of the overpayment from the provider through the TCMIS accounts receivable process.

The Contractor shall ensure it meets all federal laws and regulations with regard to privacy, security, and individually identifiable health information pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended and the Health Information Technology for Economic and Clinical Health Act (HITECH) under the American Recovery and Reinvestment Act of 2009 (ARRA), and as specified in the Facilities Management General Operations Section A.3.20.

The Contractor shall deliver, maintain and operate the TCMIS in full compliance with the HIPAA and HITECH. EDI requirements can be found in Section A.3.19.

The Contractor shall be responsible for HIPAA compliance of the TCMIS regardless of its status as a covered entity or business associate of the Bureau.

The actual damages for the Contractor's failure to comply with HIPAA and HITECH shall be any and all costs associated with the reporting, mitigation, remediation and any and all other federal or state law requirements including, but not limited to, civil money penalties assessed against the Bureau.

B.3 Liquidated Damages

B.3.1 Damage Provisions

All requirements described in this Contract are subject to monitoring by the Bureau of TennCare. The Contractor shall track and comply with all performance measures, commitments and requirements. Upon the completion of the Dashboard Enhancement, the parties shall agree upon the reports and performance measures that will be included in the compliance dashboard to track completion of Contractor commitments. The Bureau reserves the right to monitor performance at any time and may exercise such option, at its discretion, without notice. In the event of a failure to meet the performance requirements, the Contractor agrees that the Bureau of TennCare may, in its sole discretion and upon issuance of an Assessment of Actual Damages/Liquidated Damages Notice after having complied with

the Control Memorandum process set forth in Section A.1, assess actual or liquidated damages and withhold such damages from payments due to Contractor. If not specifically designated, actual and liquidated damages, if any, shall be assessed on a monthly basis. The Bureau has sixty (60) days from the end of the month in which the State becomes aware of a deficiency to issue a Control Memorandum with an ORR or a Control Memorandum with a Potential Actual damages/Potential Liquidated Damages Notice regarding the deficiency that may give rise to Actual or Liquidated Damages.

Payment of Liquidated Damages

It is further agreed by Bureau and the Contractor that any liquidated damages assessed by Bureau shall be due and payable to Bureau within thirty (30) calendar days after Contractor receipt of the Control Memorandum containing an Assessment of Liquidated Damages Notice as set forth in Section A.1.2.4.5(f) of the Contract. If payment is not made by the due date, said liquidated damages may be withheld from future payments by Bureau without further notice. It is agreed by Bureau and the Contractor that the collection of liquidated damages by Bureau shall be made without regard to any appeal rights the Contractor may have pursuant to this Contract; however, in the event an appeal by the Contractor results in a decision in favor of the Contractor, any such funds withheld by Bureau shall be immediately returned to the Contractor.

Deduction of Damages from Payments

Amounts due the Bureau as liquidated damages may be deducted by the Bureau from any money payable to the Contractor pursuant to this Contract. The Bureau shall notify the Contractor in writing of any claim for liquidated damages at least thirty (30) calendar days prior to the date the Bureau deducts such sums from money payable to the Contractor. Such amounts as they relate to Section C.3 of the Contract may be deducted during the entire period that MMIS certification is lacking. Should certification subsequently be granted retroactively, the Bureau shall reimburse the Contractor for any amounts that have been withheld due to lack of certification.

Waiver of Liquidated Damages

Bureau may waive the application of liquidated damages and/or withholds upon the Contractor if the Contractor is placed in rehabilitation or under administrative supervision if Bureau determines that such waiver is in the best interests of the TennCare program and its enrollees.

The Bureau may also waive the assessment of Liquidated Damages at its sole discretion, for any failure of performance by the Contractor.

The Liquidated Damages will be managed by the Control Memorandum(a) process as contained in A.1 of the Contract. Failure to complete or comply with an ORR may result in the assessment of Liquidated Damages in the amount of one hundred dollars ($100.00) per business day starting on the business day after the ORR due date. All due dates requested during this process shall be reasonable and shall not include weekends or holidays. Failure to complete or comply with a Control Directive deliverable may result in the assessment of liquidated damages in the amount of five hundred dollars ($500.00) per business day starting on the calendar day after the deliverable due date. This damage assessment shall not include weekends and holidays.

B.3.2 Liquidated Damage - Failure to Meet Contractor Performance Requirements

It is agreed by the Bureau and the Contractor that, in the event of a failure to meet the performance requirements listed in the following sections, damage is deemed to have been sustained by the Bureau. It is further agreed that it is and will be impractical and extremely difficult to ascertain and determine the actual damage that the Bureau has sustained or will sustain in the event of, and by reason of, such failure. It is therefore agreed that the Contractor shall pay the Bureau for such failures at the sole discretion of the Bureau according to the following business areas and subsections.

Damage assessments are linked to performance of operational responsibilities. Where an assessment is defined as an "up to (amount)," the dollar value per occurrence may be set at the discretion of the Bureau of TennCare, up to the amount specified.

For those requirements subject to a corrective action plan, written notification of each failure to meet a performance requirement shall be given to the Contractor by the Contract Administrator or his/her designee. The Contractor shall comply with the requirements of the approved corrective action plan. Liquidated Damages, if assessed, shall start to accrue on the first business day after the deliverable is not met The imposition of liquidated damage is not in lieu of any other remedy available to the Bureau.

General Liquidated Damages - In the event that the Contractor has failed to meet a performance requirement that is set out in the Contract, but for which the Liquidated Damages standards are not spelled out in this Attachment, the Bureau may assess Liquidated damages under this General Liquidated Damages provision. The Liquidated Damages will be assessed at the rate of five hundred dollars ($500.00) per business day until the requirement has been met.

The State, in its sole discretion, may elect not to assess Liquidated Damages against the Contractor in certain instances, including but not limited to the following:

- Where the Bureau determines that only inconsequential damage has occurred unless the deficiency is part of a recurring or frequent pattern of deficiency with regard to one (1) or more Contract deliverables or requirements.
- For performance measures that are resolved based on the Contractor's corrective action plan
- If the failure is not due to Contractor fault (i.e. caused by factors beyond the reasonable control and without any material error or negligence of the Contractor, its staff or subcontractors)
- Where no damage or injury has been sustained by the State
- Where the failure does not result in increased Contract management time or expense
- Where the failure results from the State's failure to perform
- Where the failure is caused by upgrades or performance of State-owned third party licensed software or hardware
- For other reasons at the Bureau's sole discretion

B.3.2.1 Deliverables

For any Deliverable not completed and submitted to, and accepted by the Bureau by the expected completion date, payment directly associated with that deliverable shall not be made to the Contractor. In addition, Liquidated Damages may be assessed by the Bureau.

B.3.2.2 Sanctions by CMS – Consequential Damages

If CMS imposes fiscal sanctions against the Bureau as a result of the Contractor's or any subcontractor's wrongful action or inaction, the Contractor shall compensate the Bureau the amount lost by the Bureau by application of the sanctions.

B.3.2.3 Enhancements

Failure to develop and implement any of the Enhancements to the TCMIS by the approved Work Plan delivery date, or if any of these Enhancements negatively impact the operations of the TCMIS, then no payment shall be made to the Contractor for that Enhancement until resolution and damages may be assessed by the Bureau.

B.3.2.4 Recovery

If, in the reasonable judgment of the Bureau, a default by the Contractor is not so substantial as to require termination and reasonable efforts to induce the Contractor to cure the default are unavailing, and the default is capable of being cured by the Bureau or by another resource without unduly interfering

with continued performance by the Contractor, the Bureau may provide or procure the services reasonably necessary to cure the default. In which event the Contractor shall reimburse the Bureau for the reasonable cost of the services. In addition, the Contractor shall cooperate with these resources in allowing access to the computer facility, documentation, software, utilities, and equipment. The Contractor shall remain liable for all system performance criteria, maintenance of and further enhancements to any applications developed by these resources to the extent that it constitutes the Contractor's work product whether impacted by the work of the other resource or not.

B.3.2.5 Intentionally Left Blank

B.3.2.6 Milestones or Phases

Requirements:

Unless otherwise specified, key milestones and phases that occur during the Planning, Design, Development, Testing, and Implementation Phases associated with Special Projects and Enhancements shall be completed by the Contractor in final form on the dates specified in the approved Work Plan. The Bureau shall review and provide written acceptance of all key milestones or phases.
The liquidated damages shall be one thousand dollars ($1,000) per workday for each day the key milestone or phase is late or unacceptable.

B.3.2.7 Sponsorship

Requirements:

Any publicity given to the program or services, including, but not limited to: notices, information pamphlets, press releases, research, reports, signs, and similar public notices prepared by or for the Contractor shall be pre-approved by the Bureau prior to release.
The liquidated damages shall be five thousand dollars ($5,000) per incident in which the Bureau approval is not obtained.

B.3.2.8 Performance Reporting System Report-Timeliness

Requirements:

The Contractor shall provide a monthly compliance report produced by the Performance Reporting System in a manner acceptable to the Bureau, within fourteen (14) workdays of the end of the month. The liquidated damages for failure to provide the report timely or in a manner acceptable to the Bureau shall be five hundred dollars ($500) a day for each workday the report is not received or acceptable.

B.3.2.9 Key Staff Thresholds

Requirement:

The Contractor shall be required to meet the minimum staffing level requirements of the Contract for the Key Staff positions as listed in Section A.6.2.

Liquidated Damage Assessment:

If the Contractor fails to comply with the thirty (30) calendar day notice requirement, where possible, the liquidated damage assessment shall be five-hundred dollars ($500) per business day until a resume for a qualified candidate is submitted and such candidate is reasonably available.

If the Contractor fails to comply with the submission of a resume of an appropriately qualified individual within sixty days, the Liquidated Damage assessment shall be $500 per business day.

B.3.2.10 Other Staff Thresholds

Requirement:

Unless otherwise approved through Control Memorandum process, the Contractor shall be required to meet the minimum staffing level requirements of the Contract for Maintenance and Modifications Staff, as listed in Section A.6.3 and Operations Processing Staff, as listed in Section A.6.4.

Liquidated Damage Assessment:

If the Contractor fails to comply with these staffing level requirements for a given month, the Liquidated Damage assessment shall be $4,000.00 per Maintenance and Modification person below the allowable threshold and $1,000.00 per Operations Processing staff below the allowable threshold.

If the Contractor fails to comply with the on-site or dedicated staffing level requirements, the Liquidated Damage assessment shall be $500 for that month.

B.3.3 Liquidated Damages: Failure to meet Contractor Commitments

The Contractor shall, at all times, operate the TCMIS and its activities in conformity with the policies and procedures of the Bureau. The Bureau and Contractor agree that any delay or failure by Contractor to timely perform its obligations by the dates in the approved Work Plan and in accordance with the Performance Commitments will interfere with the proper and timely operations of the System and Facilities Manager services, to the loss and damage of the Bureau. Further, the Bureau will incur costs to maintain the functions that would have otherwise been performed by Contractor. The Bureau and the Contractor understand and agree that this Section describes the liquidated damages the Contractor shall pay to the Bureau at the Bureau's discretion as a result of nonperformance hereunder by the Contractor.

All requirements described in this Contract are subject to monitoring by the Bureau. The Bureau reserves the right to monitor performance at any time and may exercise such option, at its discretion, without notice. The assessment of penalties shall not constitute a waiver or release of any other remedy the Bureau may have under this Contract for the Contractor's breach of this Contract, including without limitation, the Bureau's right to terminate this Contract. The Bureau shall be entitled in its discretion to recover actual damages caused by the Contractor's failure to perform its obligations under this Contract.

If the system-related Enhancements fail to meet performance commitments due to the unexcused failure on the part of the Contractor during the year following their implementation and while the Contractor is providing Facilities Management services, the Contractor shall modify, reconfigure, upgrade or replace software and equipment at no additional cost to the Bureau in order to provide a system solution that complies with such performance standards. Contractor is not liable for upgrades or performance of State-owned third party licensed software or hardware.

The Bureau confirms that the amounts stated for each occurrence of each performance failure defines the maximum compensation due from the Contractor and that the amount claimed shall be adjusted downward to eliminate any proportion of the cost caused by the Bureau's failure to meet its contractual responsibility, or for any other reasonable cause at the discretion of the Bureau. Liquidated Damages, if assessed, shall start to accrue on the first business day after the deliverable was not met.

B.3.3.1 MMIS Certification

The TCMIS System, and all of its subsystems and components, shall meet federal certification requirements defined in the most current version of Part 11 of the State Medicaid Manual. It is imperative that the enhanced TCMIS be complete, stable, fully operational, and of the highest quality. Federal authorities may elect to review the TCMIS and re-certify that the system operations continue to meet Federal MMIS standards. The Bureau shall notify the Contractor if such review is requested. The following subsection listed below describes the Certification-related activities. This list may not be all

inclusive; it is the responsibility of the Contractor to ensure that all Certification activities contained within the Contract and Part 11 of the State Medicaid Manual meet the requirements.

Reference or Contract section – Listed below: A.5.2 MMIS Certification

The following table lists the operational responsibilities and performance expectations that the Bureau has for MMIS Certification and related activities.

MMIS Certification Table

MMIS Certification Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
Contractor shall demonstrate that TCMIS processes meet Certification requirements (system reports, file updates, documentation updates).	If CMS does not grant System Certification as scheduled in the Enhancements Work Plan, the Bureau may assess Liquidated Damages from the start of operations date and until CMS certification is achieved and CMS notification of decision is received in writing.	Retroactive to the beginning of the certification review period.	The Bureau may assess any FFP damages which is the difference between the maximum allowable FFP from what was actually received by the Bureau over the same time period. These damages may be retroactive from the start of operations if so found by CMS. Additionally, the Bureau may assess one thousand dollars ($1,000) per calendar day from the start of operations date and until CMS certification is achieved and CMS notification of their decision is received in writing.	
Contractor shall comply with CMS Certification requirements as the TCMIS is maintained.	CMS fails to approve certification, and withholds FFP for any month, or portion thereof.	Retroactive to the beginning of the certification review period.	The damage that may be assessed shall be whatever damages or penalties CMS assesses.	

B.3.3.2 Change Management

It shall be the responsibility of the Contractor to ensure all Change Management activities contained within the Contract meet the requirements. This list may not be all inclusive; it is the responsibility of the Contractor to ensure all Change Management activities contained within this Contract meet the requirements.

Reference or Contract section – Listed below: A.1.2 Project Management and Approach A.4 Change management

The following table lists the operational responsibilities and performance expectations that the Bureau has for change management activities.

Change Management Table

Change Management Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
Contractor shall provide monthly reports of all open systems changes, including a three (3) month projection of the estimated release plan.	The report shall be delivered or made available electronically to the Bureau within one week after the end of each month	Monthly	The damage that may be assessed shall be one hundred dollars ($500) per calendar day for each day the system changes report is not made available timely. If the report is received on time but the information reported is inaccurate or incomplete, the Bureau may assess up to one hundred dollars ($100) per calendar day until an acceptable report is received.	
Contractor shall provide monthly report of total staff time spent by job category on system Maintenance, Modifications and Total (A.6.1)	Produce a monthly staffing report within two weeks after the end of each month (Report shall be cumulative by month for the prior 3 months, including any retroactive updates).	Each month	The damage that may be assessed shall be one hundred dollars ($500) per calendar day for each day an acceptable report is not received, unless waived by the Bureau. If the report is received on time but the information reported is inaccurate or incomplete, the Bureau may assess up to one hundred dollars ($100) per calendar day until an acceptable report is received.	
Contractor shall post in the State Approved Change Management System an estimate of scale (A.4.2.3.2)	Produce Change Request response information timely.	Within five (5) business days of Bureau request.	The damage that may be assessed shall be one hundred dollars ($100) per business day for each day an acceptable response is not received, unless waived by the Bureau. If the report is received on time but the information reported is inaccurate or incomplete, the Bureau may assess up to one hundred dollars ($100)	

Change Management Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
			per business day until an acceptable report is received.	
Contractor shall provide workgroup status meeting minutes within three (3) business days of the meeting.	Produce and distribute meeting minutes within three (3) business days of workgroup status meeting.	Within three (3) business days of workgroup status meeting.	The damage that may be assessed shall be one hundred dollars ($100) per business day for each day past deliverable period.	
Contractor shall report the age of each open maintenance items and calculate the percentage completed within ten (10) business days	Aging information made available to the Bureau monthly.	Within one (1) week after the end of each month	The damage that may be assessed shall be one hundred dollars ($100) per business day for each day past deliverable period.	

B.3.3.3 Claims Control and Entry Functions

The Claims Control and Entry functions shall ensure that all paper claims, including UB04, CMS-1500, 94, NCPDP, and crossover claims forms, and related input to the TCMIS are captured in an accurate manner at the earliest possible time. These functions shall monitor the movement and distribution of claim batches once they are entered into the system to ensure an accurate trail from receipt of claims through data entry to final disposition. The function shall include both manual and automated processes for claim control.

Additional objectives of this function of the TCMIS are to:

Maintain control over all transactions during their entire processing cycle.
Provide accurate and complete registers and audit trails of all processing.
Monitor the location of all claims at all times.

It is the responsibility of the Contractor to ensure all Claims Control activities contained within the Contract meet the requirements.

Reference or Contract sections – Listed below: A.3.11 Claims/Encounter Claims

The following table lists the operational responsibilities and performance expectations that the Bureau has for Claims Control and Entry-related activities.

Claims Control Table

Claims Control Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
Assign a unique	Produce a report of	Within one (1)	The damage that	

Claims Control Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
control number to every claim, attachment, and adjustment request received within one (1) business day of receipt at the Bureau's site.	all claims with the date the claim was received and the date control number was assigned.	business day of receipt.	may be assessed shall be one hundred dollars ($100) per business day per claim/attachment for each day past deliverable period.	
Return paper claims missing required data within one (1) business day of receipt.	Produce a report of all paper claims returned due to missing data with the date the claim was received and the date the claim was returned.	Return paper claims within one (1) business day of claim receipt.	The damage that may be assessed shall be one hundred dollars ($100) per business day per claim for each day past deliverable period.	
Document image every claim, attachment, and adjustment request within one (1) business day of receipt.	Produce a report of all claims, attachments, and adjustments with the date the claim and associated information was received and the date claim or associated information was imaged.	Within one (1) business day of receipt of claim / attachment/ adjustment receipt.	The damage that may be assessed shall be one hundred dollars ($100) per business day per claim/ attachment /adjustment for each day past deliverable period.	
Create and store a document image of Bureau-identified reports within one (1) business day of report generation.	Produce a report of all reports with the date the report was generated and the date the report was loaded to the report repository.	Within one (1) business day of report production.	The damage that may be assessed shall be one hundred dollars ($100) per business day per report for each day past deliverable period.	
Retain hard-copy documents and claims on-site until the batch is fully adjudicated and the retention schedule has lapsed.	Contractor shall have documents on-site for Quality Control (Q/C) audits to uphold performance requirements.	As frequently as claims batches are received.	The damage that may be assessed shall be one hundred dollars ($100) per day per batch for each business day prior to the retention schedule lapsing.	
Enter all paper claims within five (5) business days of receipt, unless otherwise approved by the Bureau.	Produce a report of all claims with the date the claim was received and the date the claim was entered in the TCMIS.	Within five (5) business days of claims receipt.	The damage that may be assessed shall be one hundred dollars ($100) per business day per claim for each day past deliverable period.	

B.3.3.4 Claims/Encounter Pricing and Adjudication

The Claims/Encounter Pricing and Adjudication function accepts and processes claims and encounter transactions input via paper or electronic media. This function shall accept claims/encounters entered through the claims control and entry process, perform extensive validity checks (edits and audits), and adjudicate and price approved claims according to Bureau policy. Claims pricing and adjudication shall be comprised of the following activities:

1) Edit/Audit Cycles - Process claims and encounters through preliminary edits/audits to verify that required fields are present and in the appropriate format, are consistent and reasonable, and contain allowable values. Check for data conflicts between fields within the transaction.

2) Claims Correction - Provide for suspended claims to be accessed and reviewed by claims resolution staff for disposition of the claim (e.g., data corrected, forced, denied, or manually priced), according to Bureau policy.

3) Claims Pricing - After editing, the system shall automatically calculate the allowed amount for claims and encounters according to Bureau policy. The pricing function shall include the ability to accommodate deductions and add-ons to the calculated allowed amount such as enrollee co-payments or payments from other insurance carriers. TennCare enrollees must pay a share of the cost of their health care services, which results in co-payments being required for certain specific services. Pharmacy co-pays apply to TennCare Standard enrollees as well as certain non-institutional Medicaid adults.

4) Claims exceeding the limits or audit criteria shall be reviewed by the Contractor or Bureau staff using the Bureau-approved adjudication guidelines. Corrections to the claims shall be made and applied to the claim record. Claims that do not exceed any of the file limits or audit criteria shall be finalized.

5) Claims History - All pending and paid/denied claims and encounters and their disposition (such as claims data, edits/audits applied and processing dates) and encounter claims shall be maintained for each enrollee. Health insurance payments, estate recovery actions, SUR audits, or other adjustments to claims shall also be maintained. This information shall be maintained online then archived for storage according to a Bureau-defined schedule. Certain claims, such as those for once-in-a-lifetime surgical procedures, shall never be purged from online claims history.

6) The Encounter processing function shall process encounter claims as health plan encounter records submitted to the TCMIS under the Bureau's managed care program. This function shall accept, edit, price, and process encounter claims in accordance with Bureau edit guidelines. Encounter processing shall have limited auditing and history update, and shall bypass the remittance and check write flow. It is the responsibility of the Contractor to ensure all Claims Encounter activities contained within the Contract meet the requirements.

Reference or Contract sections – Listed below: A.3.11 Claims/Encounter Claims

The following table lists the operational responsibilities and performance expectations that the Bureau has for Claims/Encounters Pricing and Adjudication-related activities.

Claims / Encounter Adjudication Table

Claims / Encounter Adjudication Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
Meet all CMS and audit review processing requirements.	Publish reports to the report repository that demonstrate the Contractor meets all CMS and audit processing requirements.	Agreed upon timeframe whenever required by CMS and the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per business day per audit requirement for	

Claims / Encounter Adjudication Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
			each business day past deliverable period, if not completed by the agreed upon timeframe.	
Perform daily claims batch processing cycles.	Produce a report that documents the time of each daily claim processing cycle.	Perform daily claims batch processing cycle each night according to Production schedule.	The damage that may be assessed shall be one hundred dollars ($100) per business day that claims cycles are late due to Contractor issues.	
Perform online, real-time adjudication of all claims transmitted interactively except for the maintenance period each week, unless otherwise authorized, in advance, by the Bureau.	Produce a monthly summary report of adjudicated claims.	Adjudicate claims submitted online within thirty (30) calendar days of receipt.	The damage that may be assessed shall be one hundred dollars ($100) per business day for each day past the deliverable period, unless waived by the Bureau.	
Process provider-initiated adjustments according to the following standards: Ninety-five percent (95%) within twenty (20) calendar days of receipt.	Produce a report that documents the percent of provider-initiated adjustments processed within twenty (20) days and thirty (30) days by provider-initiated adjustment receipt date.	Within twenty (20) days of adjustment receipt; or within thirty (30) days of receipt.	The damage that may be assessed shall be one hundred dollars ($100) per adjustment that is not processed within the specified timeframes.	One hundred percent (100%) within thirty (30) calendar days of receipt.
Provide the Bureau with document imaging, facsimiles, or hard-copy original claims, adjustments, attachments, non-claim transaction documents, and all electronic billings for all transactions processed within five (5) business days, upon request.	Produce a report that documents all requests associated with document imaging, facsimiles, or hard-copy original claims, adjustments, attachments, non-claim transaction documents, and all electronic billings for all transactions with the date the request was received by the Contractor and the date the requested information was received by the Bureau.	Within five (5) business days of transaction receipt.	The damage that may be assessed shall be one hundred dollars ($100) per business day per document or transaction for each day past the deliverable period.	

B.3.3.5 Claims Reporting and Financial Processing

The Claims Reporting and Financial processing function provides the overall support and reporting for all of the claims processing and financial activities necessary to support the Tennessee medical assistance programs. It includes activities for claim payment processing, adjustment processing, accounts receivable processing, and financial transaction processing. This function ensures that all Bureau funds are appropriately disbursed for claim payments and that all post-payment transactions are applied accurately.

The Claims Reporting and Financial Processing function is the last step in claims processing. It provides the detailed information for provider checks, provider claim reports, and the financial reports. It includes:

1) Payment Processing - Claims that have passed all edit, audit, and pricing processing, or which have been denied, are passed on for payment processing.

2) Adjustment Processing - Adjustments to be processed in the regular claims processing cycles.

3) Other Financial Processing - Financial transactions such as voids, credits, returned warrants, manual checks, cash receipts, repayments, recoupments, cost settlements, accounts receivable, cash receipts, canceled warrants, levies, garnishments and non-claim-related system payments (payouts) will be processed as part of the Claims Reporting and Financial function.

It is the responsibility of the Contractor to ensure all Claims Reporting and Financial Processing activities contained within the Contract meet the requirements.

Reference or Contract sections – Listed below: A.3.9 Accounting/Financial/Premium Management A.3.11 Claims/Encounter Claims

The outputs of the Claims Reporting and Financial Processing function shall meet all federal and State reporting requirements, and shall provide the information necessary to assess compliance with federal certification and audit review standards. The outputs shall be produced on paper, document imaging, online display, direct transmission, and electronic media, as directed by the Bureau.

The following table lists operational responsibilities and performance expectations that the Bureau has for Claims Reporting and Financial-related activities.

Claims Reporting and Financial Processing Table

Claims Reporting, Financial processing Commitment	**Performance Indicator**	**Deliverable Period**	**Liquidated Damage**	**Additional Assessment Criteria**
Contractor shall be responsible for timeliness of issuing payment files	Claims File or financial transaction is transmitted prior to the intended check date.	Per financial cycle	The damage that may be assessed shall be one thousand dollars ($1,000) for any transmission that cannot be submitted within one day of the intended date due to contractor issues.	
Perform at least one (1) payment	Produce a report that documents the	At least weekly,	The damage that may be assessed	

Claims Reporting, Financial processing Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
cycle weekly on a schedule to be approved by the Bureau.	date and time of each weekly payment cycle and the Bureau scheduled date and time for the payment cycle.	according to production schedule.	shall be one hundred dollars ($100) per business day the payment cycle is delayed from approved Bureau schedule due to Contractor issues.	
Generate and distribute enrollee EOMBs no less frequently than every quarter.	Report to the Bureau the date EOMBs are sent to enrollees	At least quarterly	The damage that may be assessed shall be one hundred dollars ($100) per business day the distribution of EOMBs is delayed due to Contractor issues.	
Produce, and submit to the Bureau, weekly reports on accounts receivable collections and outstanding balances, with individual detail and aggregate totals.	Publish all reports to the report repository, or hardcopy if requested by the Bureau.	Within one (1) business day after financial cycle.	The damage that may be assessed shall be one hundred dollars ($100) per business day per report, that the weekly reports are late due to Contractor issues.	
Process to completion all adjustments resulting from system-caused or Contractor-caused errors.	Produce a report of all adjustments resulting from system-caused or Contractor-caused errors with the date the adjustment was identified and the date the adjustment was processed.	Within the later of twenty-five (25) calendar days of identification, or as directed by the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per business day per adjustment error if delayed from processing due to Contractor issues.	
Accommodate all Bureau requests for system-generated adjustments in a timely manner, (e.g. large corrections from inappropriate payments reported to the Bureau, State or federal	Produce a report that lists when adjustment requests were made and the date they were actually done. If adjustment requests exceed five (5) business days, damages may be assessed.	Within five (5) business days of scheduled process, or of Bureau request.	The damage that may be assessed shall be one hundred dollars ($100) per business day that the system-generated adjustments are not processed after scheduled or the Bureau	

Claims Reporting, Financial processing Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
audits, or retroactive Bureau policy changes.)			requested date.	
Create weekly sample from which to perform quality control testing.	Produce a list with the weekly sample.	Weekly or as required by the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per business day the weekly Q/C sample is late from processing or delivery.	
Update system and operations documentation within ten (10) business days of when system changes are made and update detail systems design documents (DSDs) on a release by release basis.	Produce a report that lists when system changes are made and when system and operations documentation are actually updated.	Monthly, or when requested by the Bureau, or at least on a release by release basis.	The damage that may be assessed shall be one hundred dollars ($100) per business day per systems change for which systems change / operations documentation / DSD is not updated.	

B.3.3.6 Intentionally Left Blank

B.3.3.7 Provider Subsystem

The Provider Subsystem maintains comprehensive current and historical information about all providers, including, but not limited to, medical and non-medical providers and managed care entities that are eligible to participate in TennCare. It ensures that only eligible providers who agree to comply with the program rules and regulations are reimbursed for furnishing services to eligible enrollees.

The following table lists the operational responsibilities and performance expectations that the Bureau has for Provider related functions.

Provider Table

Provider Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Operate and support the AVRS system to support provider inquiries	Notify Bureau management if AVRS is not available.	Twenty-four (24) hours per day, seven (7) days per week, excluding scheduled maintenance periods.	The damage that may be assessed shall be one hundred dollars ($100) per calendar day that the AVRS component is not functioning correctly due to Contractor issues.	
Provide online access and updates to Provider data within normal business hours.	Notify Bureau management if online access is not available.	Daily	The damage that may be assessed shall be one hundred dollars ($100) per business day that the Provider component is not available due to Contractor fault.	

B.3.3.8 Eligibility Subsystem

The primary purpose of the Eligibility Subsystem is to accept and maintain an accurate, current, and historical source of eligibility and demographic information on individuals who have been or currently are eligible for TennCare. The maintenance of enrollee data is required to:

Support fee-for-service (FFS) and encounter claims processing, third-party liability cost-avoidance and recovery, managed care payment processing, health insurance and Medicare premium payment processing, and management and administrative reporting functions.

Accomplish automated interfaces with other systems.

Provide eligibility verification data to providers and other parties. The enrollee data maintained in this area also supports the maintenance of enrollee benefit limitations and the generation of various enrollee reports.

Up to twelve (12) years of TennCare eligibility data shall be maintained by the Contractor in an electronic file in the TCMIS. Updates to this file shall be received through electronic transactions. Refer to Section A.3.2.1 for the Interface Listing.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Eligibility related functions.

Eligibility Table

Eligibility Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Complete processing of ME packet within three (3) business days of receipt.	Upon notice of a deficiency, Contractor shall propose a CAP to remedy deficiency.	Within three (3) business days of receipt of ME packet.	The damage that may be assessed shall be twenty-five (25%) of current price per ME Packet that is incomplete after three (3) business days up to a maximum of five hundred dollars ($500) per month.	If CAP remedy is not completed, damages may be assessed.

B.3.3.9 Out-Bound Correspondence, Letters and Notices

The Contractor shall be responsible for a variety of official correspondence, letters, and notices related to eligibility application approval and denial, enrollment, premium billing, dunning notices, information verification letters, legal matters, EPSDT services, TPL questionnaires, complaints, grievances and appeals, and member services correspondences. Most all correspondence and notice items have strict distribution deadlines.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the correspondence related activities.

Correspondence Table

Out-Bound Correspondence Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Mail outgoing correspondence timely	Provide the Bureau with access to a log of mailing dates and volumes by correspondence type	Within Bureau specified timeline after receipt of printed materials.	The damage that may be assessed shall be one hundred dollars ($100) per business day until correspondences are mailed if due to Contractor fault.	
Contractor shall perform quality control reviews on all generated correspondences within twenty-four (24) hours of receiving printed documents.	Maintain control documents that lists correspondence tracking data (e.g., type produced, quantity, date quality controlled, date released for mail	Within twenty-four (24) hours (or Bureau specified timeline) of receipt of printed	The damage that may be assessed shall be one hundred dollars ($100) per business day until correspondences are verified.	

Out-Bound Correspondence Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
	processing),	documents.		

B.3.3.10 EPSDT

The Contractor shall commit to supporting EPSDT functions, which includes notification processes to enrollees to remind them of services and inform them of health screenings.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the EPSDT related activities.

EPSDT Table

EPSDT Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Support EPSDT processes to generate and mail monthly EPSDT notices.	Produce associated EPSDT processing control report and deliver within five (5) business days of schedule.	Within five (5) business days of monthly schedule.	The damage that may be assessed shall be five hundred dollars ($500) per business day until notices are produced and mailed.	
Produce annual CMS-416 EPSDT report according to Bureau specifications.	If the report is not produced within five (5) business days of due date (according to production schedule), or is inaccurate due to the fault of the Contractor, the Bureau may assess damages until remedied.	Annual, according to schedule.	The damage that may be assessed shall be five hundred dollars ($500) per business day after the due date until report is produced.	

B.3.3.11 Medicare Buy-In

The Medicare Buy-In function maintains and reports Medicare premium information that is used in Eligibility, Enrollment and Financial and Accounting functions.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Medicare Buy-In activities.

Medicare Buy-In Table

Medicare Buy-In Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Support Medicare Buy-In processes to maintain Buy-in data using Medicare update transactions.	Produce associated Buy-in processing reports within five (5) business days of production schedule.	Monthly, within five (5) business days of schedule	The damage that may be assessed shall be one hundred dollars ($100) per	

			business day after the due date until updates are processed.	
Generate premium payments for Medicare Buy-In enrollees.	Produce associated Buy-in premium processing reports within five (5) business days of production schedule.	Monthly, within five (5) business days of schedule	The damage that may be assessed shall be one hundred dollars ($100) per business day after the due date until payments are generated.	

B.3.3.12 Reference

The TCMIS Reference function maintains pricing files for procedures, drugs, and DRGs, and maintains other general reference files such as diagnosis, edit/audit criteria, edit dispositions, and error and remittance text information, including, but not limited to, benefit limit criteria and provider-specific rates for procedure codes. It provides a consolidated online source of reference information to be accessed during processing by other functions of the TCMIS, including, but not limited to, such areas as the claims processing, TPL functions, and managed care reporting functions.

The Bureau's goals in the maintenance of reference data are to:

1) Provide accurate coding and pricing verification during claims processing for all approved claim types, assistance programs, and reimbursement methodologies, including, but not limited to, capitated and fee-for-service programs.
2) Maintain flexibility in reference parameters and file capacity to make the TCMIS capable of easily accommodating changes and updates in coding standards in the Tennessee medical assistance programs.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Reference related activities.

Reference Table

Reference Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Correctly apply all reference file/database/online updates and interfaces within the Bureau-specified time frames.	Produce a report that lists all reference updates and the date when interfaces were actually updated.	Within five business days of Bureau approval of the update or agreed upon time frames.	The damage that may be assessed shall be one hundred dollars ($100) per business day after the due date until updates are processed.	
Update drug file data, including, but not limited to, pricing information, using the file received from the Bureau-approved drug file updating service on a bimonthly basis.	Produce a report that lists the date the drug file is updated.	Within five (5) business days of receipt of the update data.	The damage that may be assessed shall be one hundred dollars ($100) per business day after the due date until update is processed.	

B.3.3.13 Intentionally Left Blank

B.3.3.14 Electronic Transactions

The State of Tennessee requires medical assistance programs providers who bill claims to submit their claims electronically, unless exempted by the Bureau. Electronic transactions allow providers to submit claims either interactively using the Tennessee Web Portal accessible from their personal computers or through national standard formats in batch submission through electronic data transmission. All claims submitted through electronic transactions shall be edited against the most current enrollee, provider, and reference files/database tables. Claims shall be assigned transaction control numbers immediately upon receipt and are downloaded nightly to the TCMIS for processing. Claims failing these edits shall be rejected for correction and resubmission. The definition of electronic claims transactions, as used in this Contract, refers to prepayment editing, response, and acceptance of claims submitted online, via point-of-sale (POS) technology or direct data transfer, with adjudication of claims through pricing.

The following table lists the operational responsibilities and performance expectations that the Bureau has for electronic transactions related activities.

Electronic Transactions Table

Electronic Transactions Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Provide online response notifications to providers within sixty (60) seconds or less for interactive claims.	Provide response notifications and post to the compliance dashboard the results of all online interactive provider responses with the date and time the claim was received and the date and time of the response notification.	Within sixty (60) seconds or less for interactive claims.	The damage that may be assessed shall be one hundred dollars ($100) per response that exceeds the time limitation due to contractor error.	
Notify providers by a confirmation notice for batch transactions through standard X12N transactions.	Send the confirmation notice and post to the compliance dashboard the results of all X12N transaction confirmation notices with the date and time the X12N transaction was received and the date and time the confirmation notice was sent.	Within 1 hour after completion of the translation and compliancy verification	The damage that may be assessed shall be one hundred dollars ($100) per response that exceeds the time limitation due to Contractor fault.	
Load electronic batch claims submitted to the claims engine by providers who bill claims.	Load claims and post to the compliance dashboard the results of a monthly report of all electronically submitted claims with the date and time the	Within one (1) business day of receipt of Bureau approval by the Contractor.	The damage that may be assessed shall be one hundred dollars ($100) per claim per business day if not loaded.	

Electronic Transactions Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
	claim was received and the date and time the claim was loaded.			
Process timely all electronic batch submittals from providers who bill claims.	Process submittals and post to the compliance dashboard the results of a monthly report of all batch submittals with the date and time the batch was loaded and the date and time it was processed through the Claims Engine the first time.	For routine volumes, within four (4) hours after loading (claim file volume under 10,000). For high volume submittals, within two (2) business days after loading (Claim file volume over 10,000).	The damage that may be assessed shall be one hundred dollars ($100) per business day per batch.	
Load electronic encounter files submitted to the claims engine by MCC's.	Load encounters and post to the compliance dashboard the results of a monthly report of all electronically submitted encounters with the date and time the encounter file was received and the date and time the file completed translation and was made available to the Bureau for release.	Within one (1) business day of receipt of Bureau approval by the Contractor.	The damage that may be assessed shall be one hundred dollars ($500) per encounter file per business day if not loaded.	
Process timely all electronic encounter file submittals from MCC's.	Process encounter file submittals and post to the compliance dashboard the results of a monthly report of all encounter file submittals with the date and time the encounter file was loaded after Bureau release and the date and time the file was processed to the tables and submitted to the Bureau for review.	For routine volumes, within three (3) business days after Bureau release. Unless otherwise directed by the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per business day per encounter file.	

B.3.3.15 Drug Rebate Program

The TCMIS Drug Rebate Subsystem ensures compliance with the Centers for Medicare and Medicaid Services (CMS) Drug Rebate program, established under OBRA 90. Under the Drug Rebate Program, the TennCare Program recovers cash rebates from drug manufacturers whose products are used by TennCare Program enrollees. On a quarterly basis, CMS sends a file to the State of Tennessee. This file contains National Drug Codes (NDCs), the rebate per unit amount determined by CMS using manufacturer-supplied data, and NDC correction records from previous quarters. The Drug Rebate Subsystem shall track pharmacy claims for drugs and invoices drug manufacturers using drug information and rebate amounts specified by CMS. The TCMIS shall generate quarterly invoices to drug manufacturers.

The Drug Rebate Subsystem shall maintain drug manufacturer information, records and remittance advices received from manufacturers with their rebate payments, and tracks manufacturers' adjustments and disputes, and dispute resolution. It shall also provide a crosswalk of C, J, Q, and S HCPC codes.

The Drug Rebate Subsystem shall maintain an invoice history database that contains all the NDC-level items that have been printed on the quarterly drug rebate invoices. Each entry in the database shall contain a complete audit trail of one (1) specific service quarter's NDC-level invoice item from its initial invoice to its latest appearance on an adjustment invoice. Invoice data is available for online inquiry and update. The Drug Rebate Subsystem shall allow a user to manually adjust invoice line items to assist in the adjustment and dispute resolution processes. The invoice history database shall also provide an audit trail of the manually entered adjustments and flags them for inclusion on the next adjustment invoice. Data shall be maintained on the invoice history database for a minimum of eighty-four (84) months. All disputed codes shall be kept on the database until resolved.

Drug Rebate shall automatically assess interest to the manufacturer on past-due invoice items. Interest is calculated using weekly U. S. Treasury Bill rates and is recorded at the manufacturer level. Interest shall not be calculated on items in dispute, but shall be charged after the dispute is resolved. Interest shall be charged retroactively from the date the disputed amount was originally due.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Drug Rebate related activities.

Drug Rebate Table

Drug Rebate Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Process the CMS Drug Rebate file.	Process the file and update the compliance dashboard with the dates the file was retrieved and the invoice cycle was processed.	Start the cycle to process the Drug Rebate file within fifty (50) days of the end of the calendar quarter.	The damage that may be assessed shall be one hundred dollars ($100) per file if cycle to process the file is not started within required time period, due to Contractor issues.	
Generate Final invoices and send to Bureau for review.	Generate Final invoices and update the compliance dashboard with the date the drug rebate cycle is completed and the date the drug rebate cycle final	Within three (3) business days of the completion of the drug rebate cycle.	The damage that may be assessed shall be one hundred dollars ($100) per business day if invoices are not sent to Bureau for	

Drug Rebate Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
	invoices are generated.		review, due to Contractor issues.	
Mail invoice statements to manufacturers.	Mail approved invoices and update the compliance dashboard with the date when the drug rebate invoice statements are mailed to manufactures and the quarter for the invoice.	By sixty (60) days after the end of the calendar quarter.	The damage that may be assessed shall be one hundred dollars ($100) per calendar day if invoices are not mailed due to Contractor issues	
Generate final CMS rebate file, and upload file to CMS, after invoice audits.	Produce final CMS rebate file and update compliance dashboard with the date the file is uploaded to CMS.	Upload the file to CMS within seventy (70) days of the end of the calendar quarter.	The damage that may be assessed shall be one hundred dollars ($100) per calendar day if rebate reporting data is not sent for Bureau review.	

B.3.3.16 Third Party Liability (TPL)

The current Third Party Liability (TPL) Subsystem maintains comprehensive current and historical information to support the benefit recovery functions of the Tennessee TCMIS. The Bureau uses this information to reduce its liability to pay for enrollee claims. The TPL Subsystem shall ensure that the medical assistance programs are the payer of last resort. This shall be accomplished through a combination of activities, including, but not limited to: 1) cost-avoidance (denial of payment) at the beginning of claims processing, 2) post-payment billing to private insurers when cost avoidance is not possible or when retroactive TPL coverage is added or extended, 3) benefit recovery functions when retroactive TPL coverage is added or extended, and 4) recovery from deceased enrollees' estates for services that were rendered while they were eligible.

The TCMIS shall use information gathered from a number of sources to identify liability for medical services. These shall include Medicare cross-over claims, Buy-In information, file matching with other government or private programs, and data received from county offices and the Social Security Administration. Interfaces with the Bureau's child support system and the worker's compensation program shall be maintained to obtain additional information related to third-party resources.

The Contractor shall be responsible for most automated processes related to TPL. In addition, some manual TPL-related functions shall be handled by the Contractor with ongoing coordination with the Bureau, primarily in the area of federally-mandated post-payment recovery. Bureau staff have the ultimate responsibility for collection and verification of TPL, purchase of Medicare and health insurance coverage, application of (and exceptions to) TPL utilization requirements, development of policy, development and update to TPL procedures, and coordination with CMS and other State, federal, local, or private organizations.

It is the responsibility of the Contractor to ensure all TPL activities contained within this Contract meet the requirements.

Reference or Contract section – Listed below:
A.3.12 Third Party Liability

The following table lists operational responsibilities and performance expectations the Bureau has for the TPL related activities.

TPL Table

TPL Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Update the TPL_resource table with information received from TPL contractor on a monthly basis or within twenty-four (24) hours of receipt of an updated request.	Produce a report that lists the date and time when the TPL contractor information was received and the date and time the files were processed.	Within twenty-four (24) hours of receipt of a request.	The damage that may be assessed shall be one hundred dollars ($100) per business day if TPL_resource table from TPL contractor is not processed when received, due to Contractor issues.	

B.3.3.17 Managed Care

The Bureau is responsible for the implementation and administration of Tennessee's managed care Medicaid and Child Health Plan Plus programs.

The Managed Care Subsystem of the TCMIS shall manage:

1. The contracting of a variety of managed care entities. Managed care providers may be mental health, dental, and/or medical health providers. The various types include Managed Care Organizations (MCOs), Dental Benefits Manager (DBM), Pharmacy Benefits Manager (PBM), and the Program of All-Inclusive Care for the Elderly (PACE).

2. Eligibility and enrollment of recipients. Managed care enrollment is mandatory for all recipients, excluding QMB and SLMB.

3. Payment of monthly capitation (premiums) to managed care entities.

4. Processing of encounter claims from designated managed care entities.

It is the responsibility of the Contractor to ensure all Managed Care activities contained within this Contract meet the requirements.

Reference or Contract section – Listed below: A.3.16.4 Contractor Requirements for Managed Care

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Managed Care related activities.

Managed Care Table

Managed Care Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Process payment rate updates prior to the next processing cycle.	Produce a report that lists the date when the rate updates were received by	Prior to the next processing cycle.	The damage that may be assessed shall be one hundred dollars	

Managed Care Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
	Contractor, the date the rates were processed, and the date of the next processing cycle after the rates were received.		($100) per business day if payment rates are not updated prior to required period.	
Process and complete managed care system cycles before the start of the following business day.	Produce audit reports to show system cycle process information.	Within four (4) hours of start of the following business day,	The damage that may be assessed shall be one hundred dollars ($100) per business day if managed care cycles are not run according to production schedule due to Contractor issues.	
Deliver all extract files within time frames specified by the Bureau.	Produce audit reports to show extract files produced and statistical information.	Within four (4) hours of the start of the following business day, or according to production schedule.	The damage that may be assessed shall be one hundred dollars ($100) per business day if extract files are not received according to required timeframes, due to Contractor issues.	

B.3.3.18 Management and Administrative Reporting (MAR)

The TCMIS Management Reporting function shall provide information retrieval and reporting which supports policy planning, program evaluation and decision-making, fiscal planning and control, federal reporting, and operational planning and control. Information shall be retrieved from various TCMIS files/database tables for analysis and summarization.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Management Reporting functions.

MAR Table

MAR Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Deliver management reports to appropriate Bureau staff within the time frames established by the Bureau.	Produce MAR reports according to production schedule.	Monthly, within five (5) business days from expected due date.	The damage that may be assessed shall be one hundred dollars ($100) per business day if MAR reports are not received	

MAR Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
			according to required timeframes, due to Contractor issues.	
Retain final output files for at least twelve (12) months.	Date final output files were produced and the date when they were discarded, monitored through a log.	Twelve (12) month period.	The damage that may be assessed shall be one hundred dollars ($100) per business day if MAR reports are not retained until the report is re-created or the 12 month period lapses.	
Respond to Bureau requests for information about the reports with a resolution	When the report request was received and the date when the report response was received, monitored through a log.	Within three (3) business days of request or as agreed with the Bureau	The damage that may be assessed shall be one hundred dollars ($100) per business day per report resolution.	
Perform necessary corrections, rerun, verify, and distribute management reports.	Reproduce corrected reports.	Within three (3) business days of problem identification or as agreed with the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per business day per report.	
Generate accurate CMS reports.	Produce CMS reports within required timeframe.	Prior to the federal deadline on the schedule agreed with the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per business day per report that CMS reports are late due to Contractor issues.	

B.3.3.19 Surveillance and Utilization Review (SUR)

The SUR function shall identify, report, and support the investigation of potential misuse of the medical assistance programs by providers and enrollees. The Surveillance and Utilization Review Subsystem (SURS) shall create a comprehensive statistical profile of the delivery of health care services and supplies by provider and the utilization of these services and supplies by enrollee. It shall analyze historical data, develop profiles of health care delivery, and report those users whose patterns of care or utilization deviate from normative patterns of health care delivery. In addition to the identification process, the SUR function shall provide peer group and individual-level reports which support the investigative process.

This function is a management tool to allow the Bureau to evaluate the delivery and utilization of medical care, on a per-case basis, to safeguard the quality of care and to guard against fraudulent or abusive use of the Tennessee medical assistance programs, by either enrollees or providers. These functions

shall be performed for the fee-for-service and the managed care programs. The Contractor shall be responsible for the operation and maintenance of the SUR subsystem of the TCMIS.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the SUR function.

SUR Table

SUR Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Maintain the most current sixty (60) months of paid claims and encounter claims and adjustment history, and update monthly, to support SURS reporting as directed by the Bureau.	Produce a statistics report that lists information on current claims and encounter claims that are within sixty (60) months old.	Quarterly, or as required by the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per business day per record that is found to not be retained, and is within the required time period, due to Contractor issues.	
Generate and deliver all monthly reports to the Bureau by the fifth (5th) business day following the day the SURS database was updated.	Contractor shall ensure that SURS reports are delivered by the specified timeframe.	By the fifth (5th) business day following SURS database update.	The damage that may be assessed shall be one hundred dollars ($100) per report that is beyond the required time period, due to Contractor issues.	

B.3.3.20 General System Contractor Requirements

The TCMIS Contractor shall be expected to meet all of the general requirements listed in the sections below during the term of this Contract. The general requirements apply to all phases. This list may not be all inclusive. It is the responsibility of the Contractor to ensure all General System Activities contained within this Contract meet the requirements.

Reference or Contract section – Listed below:
A.3.20 Facilities manager General Operations

The following table lists the Contractor's general TCMIS operational responsibilities and performance expectations that the Bureau requires.

General TCMIS Operations Table

General TCMIS Operations Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Contractor's access to, use and disclosure of all TennCare data, shall be consistent with the safeguarding of, data integrity,	Contractor experiences a Breach of Security as a result of failure to comply with appropriate safeguards to	Continually safeguard the system.	The damage that may be assessed shall be five hundred dollars ($500) for each security / confidentiality	Contractor may be further liable for any damages imposed on the Bureau by the State or federal

General TCMIS Operations Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
privacy, security and confidentiality according to HIPAA/HITECH, GLBA, GINA, IRC, SSA and all applicable federal and state privacy, security and confidentiality requirements.	prevent access to, use, or disclosure of the TennCare data, other than as provided for by this Contract.		breach occurrence.	government.
Contractor shall conduct demonstration of Disaster Recovery Plan (DRP)	Disaster Recovery shall be demonstrated for completeness and approved by the Bureau.	According to Project In conjunction with the Bureau's demonstration of its DRP.	The damage that may be assessed shall be one hundred dollars ($100) per calendar day beginning the first (1st) day of the month in which the disaster recovery capabilities were scheduled to have been demonstrated until the demonstration is complete and approved by the Bureau.	
The Contractor shall work with the Bureau to comply with audit findings.	Comply with Bureau requirements as a result of audit findings.	Dates will be specified by the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per business day after due date.	The Contractor may also be held responsible for any and all additional liquidated damages imposed on the Bureau by the State or federal government if finding was because of Contractor negligence.

B.3.3.21 Operations

The Contractor shall operate and maintain the TCMIS system and perform the Contractor responsibilities listed in the subsections below. All TCMIS and Facilities Manager functions shall be performed by the Contractor according to the State Medicaid Manual, all federal mandates, and all Bureau requirements, statutes, and regulations. This list may not be all inclusive. It is the responsibility of the Contractor to ensure all Operational Activities contained within the Contract meet the requirements.

Reference or Contract section – Listed below: A.1 TCMIS Project Management A.1.3 Project Start-up Approach A.3.20 Facilities Manager General Operations A.5 General Facilities Management Contractor Requirements

The following table lists the general TCMIS operations responsibilities and performance expectations that the Bureau has for the Contractor.

General Operations Expectations Table

General Operations Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Contractor shall accept responsibility for the accuracy of systems and operations documentation	Contractor shall maintain all documentation and comply with delivery requirements.	Contractor by the Modified Operations start date, and subsequently within five (5) calendar days of notice, to correct documentation.	The damage that may be assessed shall be one hundred dollars ($100) per calendar day after due date, until corrected.	The Bureau will provide prior notice to the Contractor or Contractor Reported Information for required corrections.

B.3.3.22 General Operational Responsibilities

The table on the following page lists general Bureau and Contractor responsibilities required to support the successful operation of the Tennessee TCMIS and its components. More specific requirements and performance standards are further detailed in this Contract. Nothing listed here supersedes other specific requirements listed within this Contract.

This table lists the Contractor's manual TCMIS operation responsibilities and performance expectations that the Bureau requires.

General Manual Operations Table

General Manual Operations Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Deliver to and pick up from the Bureau Mail Center, Contractor mail, reports, and other deliveries as specified by the Bureau.	Produce a daily log that lists the actual pick-up and delivery times to the Mail Center and for package pickup (including time of notification call to the recipient for package pickup).	Once in the morning and once in the afternoon, and as specified by the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per occurrence for each missed courier delivery.	
Document scheduled meetings with the Bureau in writing, summarizing the key points covered,	Produce a report that lists all meetings and documents the delivery date of the meeting	By 4:30 p.m. CT the third (3rd) business day after the meeting.	The damage that may be assessed shall be one hundred dollars ($100) per business day for	This summary shall be prepared in accordance with Bureau-approved format

General Manual Operations Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
and provide a draft of this summary to the Bureau no later than 4:30 p.m. CT the third (3rd) business day after the meeting.	documentation.		each meeting report.	and content criteria.
Submit status reports to the Bureau on a regular weekly schedule and on request.	Produce a report that lists the delivery date of all weekly status reports.	Weekly as scheduled.	The damage that may be assessed shall be one hundred dollars ($100) per business day for each status report.	
Provide Bureau-defined extract files, on request, to the Bureau to support special reporting needs.	1) Produce a log that lists all requested extracts, the date the extract was requested, and the date the extract was delivered. 2) Produce extracts	Complete updates to the 1) log within one week of the completion of each extract. 2) Complete extracts by the agreed date with the Bureau.	The damage that may be assessed shall be: 1) one hundred dollars ($100) per occurrence for failure to update the log; 2) one hundred dollars ($100) per business day for each extract request not delivered timely.	
Deliver daily, weekly, monthly, and annual reports according to the Bureau-approved schedule and media, and in accordance with the performance expectations defined in the Subsection pertaining to Reports Production Requirements.	1) Produce a log that lists all reports and the date the report was delivered and media that was used, if requested by the Bureau.	1) Update log within one week of the delivery of each report.	The damage that may be assessed shall be: 1) one hundred dollars ($100) per business day for each occurrence for failure to update the log.	

B.3.3.23 Training Contractor Requirements

The TCMIS Contractor shall be responsible for developing and delivering a broad spectrum of comprehensive training programs and related documentation and materials. The training materials and approach shall include sufficient information for trainees to accurately and efficiently perform TCMIS related tasks. Proficiency testing, quality control reviews, and where necessary, re-training shall be the responsibility of the Contractor so that the trained personnel demonstrate expected proficiency.

The Contractor shall provide a Training Plan, updated at least annually, that describes the commitment of Contractor staff to providing annual training to all providers and ongoing training to Bureau staff, affiliates, and agents as necessary. The Bureau anticipates that the Contractor shall provide training when new system features or updates have presented significant change and shall provide a training program for new users. It is the responsibility of the Contractor to ensure all Paper Claims and Correspondence Management activities contained within the Contract meet the requirements.

Reference or Contract section – Listed below: A.3.20.1 Facilities Manager Operational Requirements A.6.3.2.4 Technical Writers/Trainers

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Training functions.

Training Table:

Training Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Conduct Bureau user training sessions in accordance with the approved Training Plan.	1) Produce a report that lists the training sessions that occurred, the date the training sessions occurred, and the people that attended the training. 2) Deliver training sessions in accordance with the Training Plan	Monthly	The damage that may be assessed shall be: 1) one hundred dollars ($100) per business day if training report is not delivered, 2) $500 per session, unless waived by the Bureau.	
Computer Based Training (CBT) and Web Based Training (WBT) applications shall be accessible through a secured Intranet logon environment.	Training applications are available for Bureau use.	Initial training by Modified Operations start date, and then twenty-four (24) hours per day, three hundred sixty-five (365) days per year thereafter with the exception of Bureau-approved system maintenance periods.	The damage that may be assessed shall be one hundred dollars ($100) per calendar day that applications are not available due to Contractor issues.	
Provide training materials to the	Provide training materials of newly	One (1) month prior to delivery of	The damage that may be assessed	

Training Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Bureau for review, feedback, comments.	created or updated materials at least one month prior to the first date of the training session. Applies where the project is greater than 3 months in duration.	a training session.	shall be one hundred dollars ($100) per occurrence that training materials are not delivered in accordance with the Contract.	
Submit an annual detailed Training Plan to the Bureau for approval.	Contractor shall submit a training plan as required.	By September 1, 2009 and by July 1st of each year thereafter.	The damage that may be assessed shall be one hundred dollars ($100) per business day after scheduled date, unless waived by the Bureau.	
All Contractor workforce members shall complete TennCare-sponsored training programs, as requested, such as privacy training, pursuant to Section E.26.1.	Contractor shall submit, a roster of its active workforce with TCMIS data access as of a specified training start date and shall submit signed attestations of the specific training that is TennCare facilitated or recorded to the Bureau designee, as requested.	As requested	The damage that may be assessed shall be one hundred dollars ($100) per workforce member in non-compliance by the end of the scheduled training period, unless waived by the Bureau.	

B.3.3.24 Report Production Contractor Requirements

The Bureau's need for data and information from the TCMIS cannot realistically be met by relying on static production reports. Flexible reporting capabilities shall be supported by system hardware and software components, organizational structures, telecommunication links, knowledgeable staff, and readily available accessible databases; all of which shall work together in an efficient manner.

Required reports consist of numerous reports that are required by the federal government and others which are required by the Bureau or other State agencies.

The following table lists the operational responsibilities and performance expectations that the Bureau has for Reporting functions.

Reporting Table

Reporting Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Contractor shall produce ad-hoc or other on-request reports on the date specified in the	Deliver the ad-hoc report that includes the report name, and other auditable information to show	By the mutually agreed date	The damage that may be assessed shall be one hundred dollars ($100) per	The Contractor may negotiate with requestor if request date or specifications are

Reporting Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
report request.	requirement compliance.		business day after scheduled date,	unrealistic due to report complexity.
All reports, including copies, shall be examined for readability prior to delivery to the Bureau. Report data shall not be accepted in compressed format. Online reports will be formatted to split data into readable views.	For each report, delivered to the Bureau in the quantity and media, and to the user(s) specified by the Bureau	Contract start date and daily thereafter upon notification	The damage that may be assessed shall be one hundred dollars ($100) per report if not as specified.	
When a report is not delivered, not delivered in the required format or media, not delivered to the specified user, or does not contain the required number of copies.	Contractor shall be responsible for the timeliness and delivery of all reports and documentation.	Contract start date and daily thereafter upon notification.	The damage that may be assessed shall be one hundred dollars ($100) per business day for each report.	When a report is not delivered, not delivered in the required format or media, not delivered to the specified user, or does not contain the required number of copies.

B.3.3.25 Correspondence Management

The Bureau requests that the Contractor propose a solution to the Bureau's desire to implement a central repository and document management tools to capture, store and index documentation received by both the Bureau and the Contractor. The solution shall show all claims, provider, technical, system and other pertinent documentation and utilize user-intuitive navigation and query tools.

In addition, the Bureau desires that the ability to view document images be available on Bureau staff's individual workstations. The imaging component shall provide the Bureau the capability to access all images captured in the TCMIS. It is the responsibility of the Contractor to ensure all Correspondence Management activities contained within the Contract meet the requirements.

Reference or Contract section – Listed below: A.3. Business Process and Functional Requirements

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Correspondence Management related activities.

Correspondence Management Table

Correspondence Management Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Ensure that all documents are scanned within one (1)	Produce a report of all documents with the date the	Within one (1) business day of receipt	The damage that may be assessed shall be one	

Correspondence Management Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
business day of receipt.	document was received and the date the document information was imaged.		hundred dollars ($100) per business day per document for each day past the deliverable period.	
Retrieve and deliver original hardcopy documentation within two (2) business days of a request by the Bureau.	Produce hardcopy documentation as requested.	Within two (2) business days of a request by the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per business day per request for each day past the deliverable period.	
The Contractor shall generate and distribute correspondence within one (1) business day of an automated or manual request	Produce a report that lists the date when generated and distributed correspondence was received and the date of the request.	Within one (1) business day of a request.	The damage that may be assessed shall be one hundred dollars ($100) per business day per correspondence for each day past the deliverable period.	
Ensure system response times for searches of stored images shall not exceed a five (5) second average.	Contractor shall develop a method for tracking system response time and produce a report with an hourly average by day.	Within a five (5) second average	The damage that may be assessed shall be one hundred dollars ($100) per excessive response time occurrence.	
Ensure that the document imaging system produces complete images, correctly extracts data via ICR, and correctly indexes images.	The Contractor shall perform quality assurance reviews on document imaging processes to ensure that the quality meets contractual requirements.	Deliver assessment monthly.	The damage that may be assessed shall be one hundred dollars ($100) per quality assessment with less than 99.9% accuracy.	
Maintain data entry keying accuracy standards of ninety-nine percent (99%) for claims and other transactions.	The contractor shall perform quality assurance reviews on the accuracy of paper claims and other transactions keyed in by data capture clerks to ensure that the	Deliver assessment monthly.	The damage that may be assessed shall be one hundred dollars ($100) per quality assessment with less than 99.0% accuracy.	

Correspondence Management Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
	quality meets contractual requirements.			

B.3.3.26 Maintenance and Support

The Contractor shall be responsible for maintaining the TCMIS systems and providing maintenance support, and ensuring that the TCMIS is accessible. Maintenance support shall involve all processes necessary to meet the requirements outlined throughout this Contract. The Contractor shall perform all maintenance and support as a routine activity at no additional cost to the Bureau. It is the responsibility of the Contractor to ensure all Maintenance Support activities contained within the Contract meet the requirements.

Reference or Contract section – Listed below:
A.4.1 Maintenance Tasks

The Contractor shall provide sufficient technical staff to perform all routine systems maintenance responsibilities. Examples of maintenance support are:

Assuring claims are received through all specified channels (interactive, batch, and paper) correctly and timely.

Assuring the daily claims processing work including editing and adjudication of claims are conducted smoothly and efficiently.

Correction of defects is made promptly after the Bureau's approval of the plan of correction. A defect is defined as something that does not work according to requirements, or that affects performance standards potentially causing delays in system processing.

Extracts of historical claims are made when needed for appeals, auditors, or other Bureau projects.

Entry of all system lists, parameter, and other table updates.

Performing the activities requested by the Bureau via the official transmittal process.

The following table lists the responsibilities and performance expectations that the Bureau has for the maintenance and support activities.

Maintenance Support Table

Operational Support Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Ensure all daily, on-request, weekly, monthly, quarterly, and annual cycles are run correctly and on time.	Provide cycle monitoring information as requested by the Bureau, showing the date all cycles were run and the date when the cycles were scheduled to be run.	Each day.	The damage that may be assessed shall be one hundred dollars ($100) per occurrence where cycles are late or incorrect.	
The Contractor shall	For issues that	Contact to the	The damage that	

Operational Support Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
monitor all systems processing functions in order to minimize system or payment impact and improve processing.	arise that cause processing to stop, perform research immediately upon recognizing potential system problems in order to minimize system impact, and simultaneously inform Bureau.	Project Director or their designee within one (1) hour. Contact may initially be via telephone but must be followed up with written documentation by end of the following business day.	may be assessed shall be five hundred dollars ($500) per occurrence if notice is not completed timely.	
Submit report of system errors and failures within one (1) business day of the occurrence.	Produce a report that lists the date when a system error occurred and the date when the error was reported.	Within one (1) business day of the occurrence	The damage that may be assessed shall be one hundred dollars ($100) per day per occurrence for each day past the deliverable period.	
Proactively maintain and upgrade Contractor provided software and hardware to support Contract uptime and response time.	Produce an audit report that lists the date when upgrades were scheduled and the date when the updates actually were performed.	When required	The damage that may be assessed shall be one hundred dollars ($100) per occurrence when upgrades are not maintained as required.	
Ensure that the Bureau is notified of all available upgrades of licensed products for the systems, including but not limited to, the OS, databases, and communications, excluding the upgrades performed by OIR.	Produce a report that lists the date when Bureau-approved upgrades are scheduled or have been implemented. Available updates should identify impact and any additional costs.	Monthly. Urgent upgrades reported more frequently, as necessary.	The damage that may be assessed shall be one hundred dollars ($100) per occurrence when the report is not delivered timely	
Perform work as instructed in official transmittals. This may include extracting data from archived files.	The Contractor shall ensure that official transmittals are used when producing work orders.	As often as required.	The damage that may be assessed shall be one hundred dollars ($100) per occurrence that the transmittals are not used.	

B.3.3.27 Quality Control

The Contractor shall implement and maintain a Quality and Customer Service Assessment System. The following subsections listed below describe the Quality and Customer Service-related activities. This list may not be all inclusive. It is the responsibility of the Contractor to ensure all Quality and Customer Service activities contained within the Contract meet the requirements.

Reference or Contract section – Listed below: A.5.4 Business Continuity and Contingency Plan (BCCP) – Disaster Recovery A.5.5 Quality Assurance/Quality Improvement

Quality Control –Enhanced Test Environment

The integrated test facility (ITF) allows the Bureau and the Contractor to monitor the accuracy of the TCMIS and test proposed changes to the system by processing test claims and other transactions through the system without affecting normal operations. The test facility shall mirror production in its files, databases, processing, and reporting. The test facility shall allow for end-to-end testing, from claims entry through the financial and reporting cycles. All system and integration testing shall be performed elsewhere.

The following table lists the operational responsibilities and performance expectations relating to quality control functions upon implementation of the Enhanced Test Environment. Until this implementation, general quality control will be performed through the Control Memorandum(a) process and the general Liquidated Damages provision.

Quality Control Table

Quality Control Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Provide all test outputs within the time period determined by the Bureau.	Produce test output. Also produce an audit report that lists the date when test output was received and the date when the test output was scheduled to be received.	As specified according to the project schedule.	The damage that may be assessed shall be one hundred dollars ($100) per business day per scheduled test output for each day past the deliverable period.	
Prepare and submit to the Bureau for review a corrective action plan for deficiencies associated with the Test environment.	To remedy a defect, the Contractor shall submit a CAP that documents the date and remedial activity that will be done within a certain timeframe.	Within the agreed-upon time frame.	The damage that may be assessed shall be one hundred dollars ($100) per occurrence that the CAP is not received.	
The Contractor shall provide a report relating to the test cycle against actual processing results, within the agreed-upon time frame.	Provide information relating to test cases versus actual results.	Within the agreed-upon time frame.	The damage that may be assessed shall be one hundred dollars ($100) per business day.	
Contractor shall submit system documentation for	System documentation is submitted within the	Within one business day of the specified	The damage that may be assessed shall be one	

Quality Control Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
each scheduled production Release.	specified timeframes.	timeline.	hundred dollars ($100) per business day that the release documentation is late.	
Contractor shall submit BCCP and Disaster Recovery Plans to the Bureau.	Submission of the plans within the specified timeframes.	At least sixty (60) days prior to Modified Operations Start Date, and updated annually thereafter	The damage that may be assessed shall be one hundred dollars ($100) per business day that the BCCP and Disaster Recovery Plans are late.	

B.3.3.28 System Availability and Interfaces

The TCMIS System, and all of its subsystems and components, shall remain available for claims transactions and for exchanging information through the system Interfaces. Below is a listing of Primary Subsystems and Interfaces. This list may not be all inclusive. It is the responsibility of the Contractor to ensure all Subsystems and Interfaces contained within this Contract meet availability requirements.

Reference or Contract section – Listed below: A.5.5 Quality Assurance/Quality Improvement

The following table lists the operational responsibilities and performance expectations relating to TCMIS system availability.

System Availability Table

System Availability Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
The Contractor shall ensure that the TCMIS online access is available within normal business hours each day, except as approved by the Bureau.	TCMIS disconnections shall not be longer than five (5) minutes in a single occurrence. The Bureau or Contract Administrator shall be notified when connectivity is restored and System availability is verified.	If TCMIS online connectivity is lost for more than five (5) minutes.	The damage that may be assessed shall be five hundred dollars ($500) per normal working hour, or any part of a normal working hour thereof. Total damages may not exceed twenty thousand dollars ($20,000) per week.	The Contractor shall notify the Bureau of system unavailability.
Process all interface files (input and output) within specified timeframes according to functional area requirements.	The Contractor shall maintain daily control log of outgoing and incoming files.	Each day	The damage that may be assessed shall be one hundred dollars ($100) per business day that processing of the interface	

System Availability Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
			file(s) is late.	

B.4 Deliverables

The Contractor shall be required to submit to the Bureau certain Deliverables during the Start-up activities, and during the creation and implementation of the system Enhancements. The Liquidated Damages listed in the previous sections shall apply to ensure timely and accurate completion of all Deliverables. This list may not be all inclusive. It is the responsibility of the Contractor to ensure all Start-up, Modification and Enhancement activities, requirements and Deliverables contained within this Contract meet the requirements for timeliness and accuracy.

Liquidated Damages imposed on Deliverables are referenced in Deliverables Timeline Table this Section. . All deliverables shall be assessed by timeliness of the deliverable, and accuracy of the deliverable.

A Liquidated damage assessment for timeliness shall be measured from the expected completion date to the actual completion date, and may be one hundred dollars ($100) per day after due date, until corrected.

A Liquidated damage for accuracy shall be measured from the time the Contractor is given prior notice (or Contractor reported the inaccuracy), until five (5) calendar days after notice is given. The assessment may occur from this date (notification date plus five (5) days), to the date of correction. The liquidated damage assessment for accuracy may be one hundred dollars ($100) per day until correction is received.

Liquidated damage assessments for Deliverables are as follows:

Deliverable	Liquidated Damages	Additional Assessment Criteria
Timeliness of Reports/Recommendations	The damage that may be assessed shall be one hundred dollars ($100) per day.	When a report is not delivered, not delivered in the required format or media, not delivered to the specified user, or does not contain the required number of copies.
Accuracy of Reports/Recommendations	The damage that may be assessed shall be one hundred dollars ($100) per day per report.	Prior Notice to Contractor or Contractor Reported Information Required. If not corrected within five (5) calendar days of notice, assessment may occur from date of notification to date of corrected report delivery.

HIPAA BUSINESS ASSOCIATE AGREEMENT
IN COMPLIANCE WITH PRIVACY AND SECURITY RULES

THIS HIPAA BUSINESS ASSOCIATE AGREEMENT ("Agreement") is between **The State of Tennessee, Department of Finance and Administration, Health Care Finance and Administration, Bureau of TennCare** ("TennCare" or "Covered Entity"), 310 Great Circle Road, Nashville, TN 37243 and **HP Enterprise Services, LLC** ("Business Associate"), located at 5400 Legacy Drive, Plano, TX 75024, including all office locations and other business locations at which Business Associate data may be used or maintained. Covered Entity and Business Associate may be referred to herein individually as "Party" or collectively as "Parties."

BACKGROUND

Covered Entity acknowledges that it is subject to the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

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

LIST OF AGREEMENTS AFFECTED BY THIS HIPAA BUSINESS ASSOCIATE AGREEMENT:

Medicaid Management Information System

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

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

1. DEFINITIONS

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

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

Tenn. Code Ann. § 47-18-2107 and this Agreement. Good faith acquisition of personal information by an employee or agent of the information holder for the purposes of the information holder is not a breach of the security of the system; provided, that the personal information is not used or subject to further unauthorized disclosure.

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

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

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

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

1.7 “Electronic record” means a record created, generated, sent, communicated, received, or stored by electronic means.

1.8 “Electronic signature” means an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

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

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

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

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

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

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

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

1.16 “Required By Law” shall have the same meaning as the term “required by law” in 45 CFR § 164.103.

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

1.18 “Security Event” shall mean an immediately reportable subset of security incidents which incident would include:

a) a suspected penetration of Business Associate’s information system of which the Business Associate becomes aware of but for which it is not able to verify immediately upon becoming aware of the suspected incident) that enrollee PHI or other confidential TennCare data was not accessed, stolen, used, disclosed, modified, or destroyed;

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

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

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

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

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

1.20 “Unsecured PHI” shall mean protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or

methodology specified by the Secretary.

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

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

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

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

2.4 Mitigation of Harmful Effect of Violations. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

2.5 Reporting of Violations in Use and Disclosure of PHI. Business Associate agrees to require its employees, agents, and subcontractors to promptly report to Business Associate any use or disclosure of PHI in violation of this Agreement and to report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement. The Business Associate shall report such violation to Covered Entity immediately upon becoming aware.

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

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

deliver such information as follows:

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

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

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

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

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

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

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

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

b) If the Covered Entity elects to provide the accounting to the Individual, the Business Associate

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

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

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

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

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

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

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

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

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

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

2.14 HITECH Act Compliance. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) was adopted as part of the American Recovery and Reinvestment Act of 2009. The HITECH Act and its implementing regulations impose new requirements on Business Associates with respect to privacy, security, and breach notification. These provisions of the HITECH Act and the regulations applicable to Business Associates are collectively referred to as the "HITECH BA

Provisions." The HITECH BA Provisions shall apply commencing on February 17, 2010, or such other date as may be specified in the applicable regulations, whichever is later (Applicable Effective Date).

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

Business Associate shall, and shall require its subcontractor(s) to, be aware of the Omnibus Final rule that was published in the Federal Register on January 25, 2013, is effective March 26, 2013 and enforceable 180 days after that date. Contractor shall come into compliance on or before the enforcement date of the Omnibus Final Rule, 45 CFR Parts 160 and 164 Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act (HITECH) and the Genetic Information Nondiscrimination Act (GINA); Other Modifications to the HIPAA Rules; and the Final Rule.

Business Associate shall cooperate with State privacy officials in executing the appropriate agreements in order to comply with federal and state laws and regulations, and as amended.

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

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

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

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

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

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

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

3.5.1 Business Associate identifies the following key contact persons for all matters relating to this Agreement:

Dennis W. Vaughan, Account Executive

Business Associate shall notify Covered Entity of any change in these key contacts during the term of this Agreement in writing within ten (10) business days.

3.6 Contact for Security Event Notice. Notification for the purposes of Sections 2.5, 3.4 and 3.5 shall be in writing made by email/fax, certified mail or overnight parcel immediately upon becoming aware of the event, with supplemental notification by facsimile and/or telephone as soon as practicable, to:

Privacy Officer
Bureau of TennCare
310 Great Circle Rd.
Nashville Tennessee 37243
Phone: (615) 507-6855 Facsimile: (615) 532-7322

3.7 Security Compliance Review upon Request. Business Associate agrees to make its internal practices, books, and records, including policies and procedures relating to the security of electronic PHI received from, created by or received by Business Associate on behalf of Covered Entity, available to the Covered Entity or to the Secretary of the United States Department of Health in Human Services or

the Secretary's designee, in a time and manner designated by the requester, for purposes of determining Covered Entity's or Business Associate's compliance with the Security Rule.

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

4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

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

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

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

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

4.5 Other Uses Strictly Limited. Nothing in this Agreement shall permit the Business Associate to share PHI with Business Associate's affiliates or contractors except for the purposes of the Service Agreement(s) between the Covered Entity and Business Associate(s) identified in the "LIST OF AGREEMENTS AFFECTED BY THIS HIPAA BUSINESS ASSOCIATE AGREEMENT" on page one (1) of this Agreement.

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

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

4.8 Data Use Agreement - Use and Disclosure of Limited Data Set. Business Associate may use and

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

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

5. OBLIGATIONS OF COVERED ENTITY

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

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

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

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

6. PERMISSIBLE REQUESTS BY COVERED ENTITY

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

7. TERM AND TERMINATION

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

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

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

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

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

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

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

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

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

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

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

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

to those purposes that make the return or destruction unfeasible, for so long as Business Associate maintains such PHI.

8. MISCELLANEOUS

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

8.2 Amendment. The Parties agree to take such action to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act, Public Law 104-191. Business Associate and Covered Entity shall comply with any amendment to the Privacy and Security Rules, the Health Insurance Portability and Accountability Act, Public Law 104-191, and related regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended, including, but not limited to, changes required by the American Recovery and Reinvestment Act of 2009, Public Law 111-5.

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

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

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

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

COVERED ENTITY:

Darin J. Gordon, Director
Department of Finance and Adm.
Health Care Finance & Admin.
Bureau of TennCare
310 Great Circle Rd.
Nashville, TN 37243
Phone: (615) 507-6443
Fax: (615) 253-5607

BUSINESS ASSOCIATE:

Scott Mack, General Manager
HP Enterprise Services
SHHS – Midwest
ES State and Local HHS
5400 Legacy Drive
Plano, TX 75024
Phone: (405) 416-1515

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

location and receipt is verbally confirmed by the sender.

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

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

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

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

8.11 Validity of Execution. Unless otherwise agreed, the parties may conduct the execution of this Business Associate Agreement transaction by electronic means. The parties may agree that an electronic record of the Agreement containing an electronic signature is valid as an executed Agreement.

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

BUREAU OF TENNCARE	**HP ENTERPRISES, LLC (BUSINESS ASSOCIATE**
By: _____	By: _____
Darin Gordon, Director	***Scott Mack, General Manager***
Date:_____	Date:_____
State of Tennessee, Dept of Finance & Adm. Division of Health Care Finance and Administration 310 Great Circle Road Nashville, TN 37243 Phone: (615) 507-6443 Fax: (615)) 253-5607	HP Enterprise Services, SHHS – Midwest, ES State and Local HHS 5400 Legacy Drive, Plano, TX 75024 Phone: (405) 416-1515

Glossary

Glossary

AAU: Administrative Appeals Unit.

ACCENT: Automated Client Certification Eligibility Network for Tennessee. This Department of Human Services (DHS) information system determines TennCare Standard eligibility for Title XIX individuals and families and forwards this predetermined eligibility to the Bureau.

ACH: Automated Clearing House.

ACWP: Actual Cost of Work Performed.

AD HOC REPORT (AHR): Reports created or used for specific or immediate problems or needs. This also refers to ad hoc notices.

ADA: American Dental Association. The ADA publishes the dental procedure codes (CDT2 and CDT3) used for reporting and billing dental services.

ADA: Americans with Disabilities Act of 1990.

ADAPT: The HCBS waiver program that provides services for seniors in the home setting.

ADJUDICATED CLAIM: A claim that has moved from pending status to final disposition, either paid or denied.

ADJUSTMENT: A debit or credit transaction that corrects a previously paid claim or capitation payment.

AEM: AVAYA Enterprise Manager.

AG: Attorney General of the State of Tennessee.

ALJ: Administrative Law Judge.

AMA: American Medical Association.

ANSI X12: ANSI ASC X12 is an acronym for the American National Standards Institute Accredited Standards Committee (ANSI ASC), which is the national standards body for the development and maintenance of electronic data interchange (EDI) standards for the United States. X12 is a sequential designator assigned by ANSI at the time of accreditation with no other significance. X12 standard transactions and code sets are used in HIPAA standard transactions.

A/P A/R: Accounts Payable and Accounts Receivable.

APD: Advance Planning Document. This is a federal budget request document that a state must submit to CMS in order to receive enhanced federal funding for Medicaid systems or operations.

ARAD: A file sent from DHS of TennCare applicants who never returned to DHS for an interview after filing an application.

ARTS: Appeals Resolution Tracking System.

ARU: Audio response unit.

AS IS: The presently existing condition without modification.

ASCII: American Standard Code for Information Interchange.

ASO: Administrative Service Organization.

AUTOSYS: Software product that centralizes and automates the scheduling and management of jobs in distributed UNIX and Windows NT environments.

AVRS: Automated Voice Response System.

AWP: Average Wholesale Price.

AXIS DIRECT: Mail Vendor used by the Facilities Manager and the Bureau as of the release of the RFP.

BA: Business Services Analyst.

BAA: Business Associate Agreement (in conjunction with HIPAA Privacy and Security Rules).

BCBS: BlueCross BlueShield. BCBST is BlueCross BlueShield of Tennessee.

BCCP: Business Continuity and Contingency Plan.

BCWP: Budgeted Cost of Work Performed.

BCWS: Budgeted Cost of Work Scheduled.

BENDEX: Beneficiary Data Exchange System which is federal government information regarding persons receiving SSA benefits.

BENEFITS: A schedule of covered health care services that an eligible recipient may receive.

BHO: Behavioral Health Organization.

BUREAU: Bureau of TennCare, which may be used interchangeably with the Department of Finance and Administration and State of Tennessee.

BUSINESS ARCHITECTURE: The MITA Business Architecture provides the framework for defining a vision for the next decade for improvements in the Medicaid program operations that result in better outcomes for all stakeholders. The Business Architecture contains models of typical Medicaid business processes and describes how these processes can improve over time. A maturity model is used to show how business capabilities can evolve. States will use the Business Architecture to assess their own current business capabilities and determine future targets for improvement (from CMS Medicaid IT Architecture (MITA) Framework 2.0).

BUSINESS DAY or NORMAL BUSINESS DAY: Monday through Friday from 8:00 a.m. to 5:00 p.m. Central Time, excluding state holidays.

BUY-IN: When states may pay a monthly premium to the Social Security Administration on behalf of eligible Title XIX recipients, enrolling them in the Medicare Title XVIII Part B program.

C & I: Tennessee Department of Commerce and Insurance.

CAP: Corrective Action Plan.

CAPITATION PAYMENT: Monthly payments made to Managed Care Contractors for providing services to TennCare enrollees.

CART: Short for cartridge.

CARVED-OUT SERVICES: A separate group of services that are covered by an unconnected managed care entity (e.g., dental and pharmacy services are “carved out” from the Managed Care Organization’s responsibilities).

CARTRIDGE: A medium for storing data.

CBT: Computer Based Training.

CCB: Change Control Board.

CDT: Central Daylight Time

CERTIFICATION: The MMIS certification process is conducted to verify that a state’s TCMIS is working correctly and to validate that the process includes all necessary functionality in order for the state to receive seventy-five percent (75%) Federal Financial Participation (FFP), and to ensure that all legal and operational requirements are met by the MMIS system and its components.

CERTIFICATION DATE: The effective date specified in a written approval notice from CMS to the State when seventy-five percent (75%) FFP is authorized for the administrative costs of an MMIS.

CFR: Code of Federal Regulations.

CHA: Community Health Agencies. Interchangeable with Community Service Agency.

CHAMPUS: Civilian Health and Medical Program of the Uniformed Services.

CHANGE ORDER: A change order is used to define the requested system changes and link together all the development effort documentation.

CHR: Clinical Health Record.

CLAIM: A payment request from a provider for health care services provided to a recipient.

CLAIMS ATTACHMENT: Refers to the federal recommendation for a HIPAA standard transaction to allow payers to request additional information to support claims. The ANSI X12N Healthcare Claim Request for Additional Information (277), the ANSI X12N Additional Information to Support a Healthcare Claim or Encounter (275), and the HL7 Clinical Architecture Document (CDA) were included in the recommendation.

CLAIMS HISTORY: Historically stored claims consisting of all claim types and all subsequent adjustments that have been adjudicated by the iC TCMIS.

CLEAN CLAIM: The term clean claim refers to a claim that does contain a defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

CLIA: Clinical Laboratory Improvement Amendments.

CONTROL MEMORANDUM: Formal contract communiqué that contains the history, background, and any other pertinent information relative to the issue and/or issues being addressed in the Control Memorandum(a). Used to implement contract compliance measures.

CRG: Clinically Related Group.

CMHC: Community Mental Health Centers.

CMM: Capability Maturity Model.

CMMI: Capability Maturity Model Integration.

CMS: Centers for Medicare and Medicaid Services. This is the federal agency (formerly known as HCFA) responsible for the administration of the Medicaid, Medicare, and other health care programs.

CMS-21: Quarterly SCHIP statement of expenditures federal report.

CMS-64: A federal report entitled "Quarterly Medicaid Statement of Expenditures of the Medicaid Program".

CMS-416: Annual EPSDT federal report.

CMS-1500: The CMS-1500 form is the standard claim form used by a non-institutional provider or supplier to bill Medicare carriers and durable medical equipment regional carriers. It is also used for billing of some Medicaid state agencies.

CMS- 2082: An annual report to CMS that is a required part of the Management and Administrative Reporting Subsystem (MAR).

CMSO: Centers for Medicaid and State Operations.

COB: Coordination of Benefits.

COLD: Computer Output to Laser Disk. This utility is used to access reports stored in the iC TCMIS system.

CONTRACT: The written, signed agreement between the Contractor and the Bureau.

CONTRACT ADMINISTRATOR: State-employed staff person designated to coordinate and monitor the activities of the Contract and to resolve questions and perform other functions as necessary to ensure the Contract is appropriately administered and all terms and conditions of the Contract are met.

CONTRACTING OFFICER: The State official who has overall responsibility for the TCMIS Contract.

CONTRACTOR: The term Contractor refers to an entity with whom the State has successfully negotiated a Contract.

CONTRACTUAL TERMS IN CONTRACT: The use of the terms "shall," "must," and "will" refers to a mandatory requirement or condition to be met by the Contractor or by the Bureau. The use of the terms "may" or "should" refer to an optional requirement or condition to be met by the Contractor or by the Bureau.

COTS: Commercial Off-the-Shelf.

CPT: Common Procedural Terminology - A unique coding structure scheme for all medical procedures approved by the American Medical Association.

CPT2, CPT3: Dental procedure codes used for reporting and billing dental services.

CPU: Central Processing Unit.

CROSSOVER CLAIM: The term cross over claim refers to a claim for services rendered to an enrollee eligible for benefits under both Medicaid and Medicare programs. Medicare benefits must be processed prior to Medicaid payment consideration.

CRYSTAL XCELSIUS: A COTS product used to create the Dashboard statistics and reports.

CSA: Community Service Agency. Interchangeable with Community Health Agency.

CSR: Customer Service Representative.

CST: Central Standard Time.

CTS: Computerized Telephony System.

CVO: Centralized Verification Organization.

***DANIELS* LAWSUIT:** See TennCare Lawsuits.

DASHBOARD: Provides reporting of key operational and production metrics.

DBA: Database Administrator.

DBM: Dental Benefits Manager.

DBMS: Database Management System.

DCS: Tennessee Department of Children's Services.

DDI: Design, Development, and Implementation.

DED: Data Element Dictionary.

DEERS: Defense Eligibility and Enrollment Reporting System.

DEPARTMENT: State of Tennessee Department of Finance and Administration, which may be used interchangeably with the State of Tennessee and Bureau of TennCare.

DHCF: Division of Health Care Facilities. This department provides the LTC Unit with "read only Minimum Data Set (MDS)".

DHHS: United States Department of Health and Human Services.

DHS: Tennessee Department of Human Services.

DISABILITY: With respect to an individual, a physicalor mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.

DISENROLLMENT: A member is disenrolled or terminated from a Managed Care Contractor (MCC) plan.

DMERC: Durable Medical Equipment Review Contractor.

DMHDD: Tennessee Department of Mental Health and Developmental Disability, used interchangeably with **MHDD.**

DMRS: Tennessee Division of Mental Retardation Services.

DOC: Tennessee Department of Corrections.

DOD: United States Department of Defense.

DOH: Tennessee Department of Health.

DRG: Diagnosis Related Groups. DRGs are used to categorize like type inpatient hospital admissions.

DSD(s): Detailed Systems Design documents.

DSH: Disproportionate Share Hospital.

DSS: Decision Support System. A DSS contains the tools used to extract data from a Data Warehouse.

DUNNING: When an enrollee's premium payments have not been received.

DUPLICATE CLAIM: A claim (or encounter) that is either totally or partially an exact or near duplicate of one (1) previously billed or in process.

DUR: Drug Utilization Review.

EDB: Medicare's Enrollment Data Base.

EDI: Electronic Data Interchange.

EDIFECS: A company that produces a COTS package that performs claims and encounters front-end editing and tracking.

EDISON: An ERP system the State will use to replace STARS, among other things.

EFT: Electronic funds transfer.

EHR: Electronic Health Record.

EMC: Electronic media claims.

ENCOUNTER DATA: Data submitted by Managed Care Contractors for services provided to enrollees.

ENROLLEE: Person participating in the TennCare Program. May be used interchangeably with Member or Recipient.

ENROLLMENT: The process of adding TennCare eligibles to a MCO, BHO, DBM or PBM.

EOB: Explanation of Benefits.

EOP: Explanation of Payment.

EPSDT: Early and Periodic Screening, Diagnosis and Treatment as described in Title XIX of the Social Security Act.

EQRO: External Quality Review Organization.

EQUIPMENT: An article of nonexpendable, tangible, personal property having a useful life of more than one (1) year and an acquisition cost which equals or exceeds five thousand dollars ($5,000.00).

ERP: Enterprise Resource Planning (Edison project).

EVMS: Earned Value Management System.

EVS: Electronic Verification System.

FACILITY MANAGER (FM): The entity contracted by the State to operate, maintain, and enhance a certified TCMIS. Other responsibilities of the Facilities Manager include generating and distributing reports, and performing mailroom operations. Used interchangeably with Facilities Manager and Facilities Management.

FACILITY MANAGEMENT: The act of managing the TCMIS.

F & A: Tennessee Department of Finance and Administration, which may be used interchangeably with the State of Tennessee and Bureau of TennCare.

FCR: Financial change request.

FEDERAL MMIS GSD: Federal Medicaid Management Information System General System Design.

FEIN: Federal Employer Identification Number.

FID: Federal Identification Number.

FFP: Federal Financial Participation.

FFS: Fee-for-service.

FIRM FIXED PRICE: A single price established by the awarding of this Contract not subject to change or negotiation over the term of the Contract.

FISCAL YEAR: The federal fiscal year is October 1st - September 30th. The Tennessee fiscal year is July 1st - June 30th.

FM: Facility Manager.

FMU: Facility Manager Applications/File Maintenance Unit.

FPL: Federal Poverty Level.

FTE: Full time equivalent.

FTP: File Transfer Protocol (Internet).

FQHC: Federally Qualified Health Centers.

FTI: Federal Tax Information as identified by the federal Internal Revenue Code.

GDS: The term GDS refers to general system design, which is the Federal definitive guidelines stating all systems requirements for a certifiable MMIS.

GHI: Group Health Incorporated.

GINA: Genetic Information Nondiscrimination Act

GLBA: Gramm-Leach-Bliley Act

GRIER CONSENT DECREE: Grier Revised Consent Decree (Modified) of Grier v. Goetz. See TennCare Lawsuits.

GUI: Graphical User Interface.
HARDWARE:
1. A computer and the associated physical equipment directly involved in the performance of data-processing or communications functions; and/or
2. Machines and other physical equipment directly involved in performing an industrial, technological function.

HCBS: Home and Community Based Services.

HCFA: Health Care Financing Administration (see CMS).

HCPCS: HCFA Common Procedure Coding System.

HEDIS: Health Plan Employer Data and Information Set.

HHS: U.S. Department of Health and Human Services.

HIC: Health Insurance Claim.

HICN: Health Insurance Control Number (X-reference File)

HIE: Health Information Exchange.

HIPAA: Health Insurance Portability and Accountability Act of 1996, as amended. A federal law that includes requirements to protect patient privacy, protect security and data integrity of electronic medical records, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers.

HITECH: Health Information Technology for Economic and Clinical Health Act of 2009.

NCPDP 1.1: NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), supporting Telecommunication Standard Implementation Guide, Version 5, Release 1 (Version 5.1) for the NCPDP Data Record in the Detail Data Record.

NCPDP 5.1: NCPDP Telecommunication Standard Implementation Guide Version 5, Release 1 (Version 5.1).

PII: Personally Identifiable Information.

PHI: Protected Health Information

X12 270: Health Care Eligibility Benefit Inquiry EDI transaction.

X12 271: Health Care Eligibility Benefit Response EDI transaction.

X12 276: Health Care Claim Status Request EDI transaction.

X12 277: Health Care Claim Status Response EDI transaction, will also be the Health Care Claim Request for Additional Information in the Claims Attachment EDI transaction (but will be a different IG).

X12 278: Health Care Services Review – Request for Review and Response EDI transaction (Prior Authorization).

X12 820: Payroll Deducted and Other Group Premium Payment for Insurance Products EDI transaction.

X12 834: Benefit Enrollment & Maintenance EDI transaction.

X12 835: Health Care Claim Payment/Advice EDI transaction.

X12 837I: Health Care Claim- Institutional EDI transaction.

X12 837P: Health Care Claim- Professional EDI transaction.

X12 837D: Health Care Claim- Dental EDI transaction.

HIPP: Health Insurance Purchasing Program.

HMS: Health Management System, the Bureau TPL contractor.

HW/SW: Hardware/Software.

IC: interChange.

ICD-9-CM/ICD-10-CM: International Classification of Diseases, 9th Edition, Clinical Modification; ICD-10-CM (10th Edition), when published, will replace the current ICD-9-CM classification of disease manual.

ICF: Intermediate Care Facility.

ICF/MR: Intermediate Care Facility/Mental Retardation: An intermediate care facility providing health and mental health care and services to mentally retarded or developmentally disabled individuals who do not require hospitalization.

ICN: The ICN is an internal control number that is a unique thirteen-digit control number assigned to each claim. The format for the ICN is: YJJJMBBSSSLL
Y = year
J = Julian date
M = media code
B = batch number
S = sequence within batch
L = line number

IEEE: Industrial Electrical and Electronic Engineers.

IM: Information Management.

INSTITUTION(S): An establishment that provides care for enrollees (e.g., long term care, skilled nursing, mental health).

INTERCHANGE: The HP system to support TCMIS operations.

IO: Input/Output.

IRC: Internal Revenue Code

IS: Information Systems.

ISDM: Information Systems Development Methodology.

ISO: International Standard Organization.

IT: Information Technology.

ITM: The State's Information Technology Methodology.

IV-D: Title IV, Part D of Social Security Act (Child Support and Establishment of Paternity).

IV&V: Independent Verification and Validation.

IVR: Integrated Voice Response.

JAD: Joint Application Design - a method for defining and designing the requirements for the TCMIS.

JAR: Joint Application Requirements - a method for reviewing and modifying or designing the requirements for the TCMIS.

JCL: Job Control Language.

JOINT VENTURE: An endeavor by two or more entities who have combined resources or products.

JUDICIAL: A category of eligibility whereby the enrollee is only entitled to receive behavioral health services/evaluations as ordered by a court.

LAN: Local Area Network.

LSU: Bureau of TennCare Legal Solutions Unit.

LTC: Long Term Care.

MAC: Maximum Allowable Cost.

MAR: Management and Administrative Reporting.

MCC: Managed Care Contractors. This term is inclusive of all Managed Care Organizations (MCOs), Behavioral Health Organizations (BHOs), Pharmacy Benefits Manager (PBM), Dental Benefits Manager (DBM) and Administrative Service Organization (ASO) contracted with the State.

MCKESSON: A company that produces a COTS package that performs claims rule and data validation.

MCO: Managed Care Organization.

ME: Medical Eligibility.

MEDICAID: See Title XIX.

MEDICALLY NEEDY: Those recipients who meet Medicaid eligibility criteria but whose income and resources are above the limits prescribed for the categorically needy and are within the limits set under the Tennessee Medicaid plan.

MEDICARE: See Title XVIII.

MEDICARE CROSSOVER: Same as a crossover claim.

MEMBER: An individual enrolled in the TennCare Program. May be used interchangeably with Recipient or Enrollee.

MEQC: Medicaid Eligibility Quality Control.

MEU: Medical Evaluation Unit.

MFCU: Medicaid Fraud Control Unit.

MHDD: Tennessee Department of Mental Health and Developmental Disability, used interchangeably with DMHDD.

MITA: Medicaid Information Technology Architecture.

MMA: Medicare Modernization Act.

MMIS: Medicaid Management Information System.

MR: Mental Retardation - often used in conjunction with MHDD.

MR/DD: Mental Retardation/Developmental Disabilities.

MSIS: Medicaid Statistical Information System.

NAIC: National Association of Insurance Commissioners.

NASCIO: National Association of State Chief of Information Officers.

NCPDP: National Council for Prescription Drug Programs.

NCQA: National Committee on Quality Assurance.

NDC: National Drug Code.

NF: Nursing Facility.

NH: Nursing Home.

NIST: National Institute of Standards and Technology.

NOSC: Network Operations and Security Center.

NPI: National Provider Identifier.

OATS: Online Application Tracking System. A file used by TennCare and DHS for recipients who have applied for eligibility

OBRA '90: Omnibus Budget Reconciliation Act - 1990.

OCCP: Bureau of TennCare Office of Contract Compliance and Performance.

OCR: Tennessee Department of Finance and Administration - Office of Contract Review.

OCR: Optical Character Recognition.

OGC: Bureau of TennCare Office of General Counsel.

OIG: Bureau of TennCare Office of Inspector General.

OIR: The Office for Information Resources (OIR), a division within the Tennessee Department of Finance and Administration, is responsible for the State's centralized data processing and hosts the TCMIS at its facilities in Nashville, Tennessee. The OIR is responsible for disaster recovery and ensuring a "hot site" is available, if needed.

ONLINE: Using a computer to have immediate access to stored data.

ORACLE: A COTS software package used by the Bureau of TennCare for financials and reporting financials.

ORR: On Request Report.

OS: Operating System.

OSCAR: Online Survey, Certification and Reporting Interface.

P & T: Pharmacy and Therapeutics.

PACE: Program of All-inclusive Care for the Elderly, an elderly and disabled HCBS waiver program.

PAE: Preadmission Evaluation, an application for individuals seeking Medicaid reimbursement of nursing home care, Home and Community Based Services (HCBS) in a waiver program, and PACE services.

PAQ: Project Assessment Quotation.

PARIS: Public Assistance Reporting Information System.

PART D: Prescription drug program under the Federal Medicare Modernization Act (MMA).

PARTNERING ENTITIES: Two or more contractors or business associates combining their services or products to form a joint venture.

PASRR: Pre-Admission Screening and Resident Review.

PBM: Pharmacy Benefits Manager.

PC: Personal Computer.

PCCM: Primary Care Case Management program.

PCG: Public Consulting Group, previous TPL contractor.

PCP: Primary Care Provider.

PDF: Portable Document Format (Adobe Acrobat).

PDS: Premise Distribution System.

PM: Project Manager.

PMBOK: Project Management Body of Knowledge.

PMI: Project Management Institute.

PMO: Project Management Office.

PMP: Project Management Professional certified by the PMI.

PMPM: Per Member per Month.

POS: Point of Sale.

PQAS: Prior Quarter Adjustment Statement (drug rebate electronic interface).

PREMIUM: Refers to the amount owed by TennCare enrollees who are over one hundred percent (100%) of the Federal Poverty Level and are considered uninsured or uninsurable.

PRO: Peer Review Organization.

PROCUREMENT LIBRARY: TCMIS items for review by RFP Proposers.

PRODUR: Prospective Drug Utilization Review.

PROGRAMMER: Refers to a person who designs, writes, and tests computer programs. In reference to this Contract, a person with a minimum of two (2) years of experience in systems development and maintenance with training in the technologies used in MMIS systems.

PROLAW: The software system used to track all documentation and information related to a particular medical or reimbursement appeal and its status.

PROVIDER: Entity that provides services (e.g., medical, mental health, dental, or pharmacy).

PWB: Project Work Book.

PWP: Project Work Plan.

QI: Quality improvement.

QM: Quality Management.

QUALITY MANAGEMENT PLAN: Plan submitted by the Contractor to the Bureau describing how quality will be maintained.

QMB: Qualified Medicare Beneficiary.

RA or R/A: Remittance Advice, a document sent to providers to explain the payment, nonpayment, return or status of pended claims.

RACF: Refers to the State of Tennessee's Security System.

RBRVS: Resource Based Relative Value Scale.

RC: Release Coordinator.

RDBMS: Relational Database Management System.

RECIPIENT: An individual enrolled in the TennCare Program. May be used interchangeably with Enrollee or Member.

RECONSIDERATION CLAIMS: The process by which a MCC or the Bureau reviews and renders a decision regarding an enrollee's appeal for the MCCs adverse action affecting TennCare benefits. This may include the reconsideration claims, including, but not limited to, traditional reconsiderations (e.g., appeals) and the following: late billing, enrollee retroactive eligibility, out-of-state emergency, payment under court order, result of an appeal/fair hearing, class action suit, and any other Bureau-defined situation, in accordance with Bureau instructions.

REMITTANCE ADVICE: Document used by Medicaid agencies to reports claims payments or reasons that claims were denied or rejected, either proprietary or X12 835.

REOMB: Recipient Explanation of Medicaid Benefits.

RESOURCE LEVEL STAFFING PLAN: Listing of key staff and the corresponding job description

RETRODUR: Retrospective Drug Utilization Review.

RETURNED CLAIM: A claim which contains errors such as missing data, incorrect entries on the claim form, or conflicting information, and that is returned to the provider without being adjudicated.

REVENUE CODE: A three (3) digit code used to identify and bill for services on a UB92 claim form.

RID: Recipient Identification Number.

RIDMATCH: A process for matching Recipient Identification (RID) numbers of Medicaid recipients whose eligibility had been extended (by the iC monthly extend process), against a daily file received from DHS to process updates for which responses have been received

RFP: Request for Proposals.

RMHI: Regional Mental Health Institutes.

***ROSEN*:** See TennCare Lawsuits.

ROSI: Reconciliation of State Invoices.

RRI: Recognition Research Imaging. The forms processing solution used by the Facilities Manager to automate data capture (e.g. scanned claims and attachments).

RTE: Return to Enrollee, this term is only applicable for Medical Eligibility (ME) functions.

RTP: Return to provider.

SAK: System Assigned Key.

SAMHSA: Substance Abuse and Mental Health Services Administration

SSAE-16: Statement on Standards for Attestation Engagements

SCAMPI: Standard CMMI Appraisal Method for Process Improvement.

SCANSTATION: A system to scan documents and correspondence.

SCR: System Change Request – a modification/enhancement request for the TCMIS.

SCCS: Source Code Control System.

SDLC: Systems Development Life Cycle.

SDX: State Data Exchange.

SDS: System Development and Support.

SE: Information Analyst/Programmer Analyst/Systems Engineer.

SED: Seriously Emotionally Disturbed enrollees. This designation is for children only.

SEI: Software Engineering Institute.

SHP TIS: State Health Plan/Tennessee Insurance System, a TPL interface.

SLA: Service Level Agreement, a part of the Enterprise Service Bus (ESB).

SLMB: Special Low-Income Medicare Beneficiary.

SINGLE STATE AGENCY: The department of a state that is legally authorized and responsible for the statewide administering of the state's plan for medical assistance. The Tennessee Department of Finance and Administration, Bureau of TennCare is the designated Single State Agency in Tennessee.

SMD: State Medicaid Director.

SMM: State Medicaid Manual.

SME: Subject matter expert.

SMM: State Medicaid Manual.

SNF: Skilled Nursing Facility. A skilled nursing facility is also referred to as NF Level Two.

SOFTWARE: The programs, routines, and symbolic languages that control the functioning of the hardware and direct its operation.

SOLQ: Social Security Online Query file.

SPMI: Severely and Persistently Mentally Ill enrollees. This designation is for adults only.

SPR: Federal Systems Performance Review, which is an annual review of the MMIS performed by CMS to ensure that the system continues to meet all stated requirements.

SPRS: Service Provider Registry System.

SQL: Structured Query Language.

SSA: United States Social Security Administration.

SSI: Supplemental Security (Disability) Income for the aged, blind, and disabled.

SSN: Social Security Number.

STAKEHOLDER: An individual or group with an interest in the success of a group or an organization in delivering intended results and maintaining the viability of the group or organization's product and/or service. Stakeholders influence programs, products, and services.

STARS: State Accounting and Reporting System.

STATE: The State of Tennessee, which may be used interchangeably with the Department of Finance and Administration and Bureau of TennCare.

STATE ONLY: A category of eligibility whereby the enrollee is only entitled to receive behavioral health services as approved by the Department of Mental Health.

STEERING COMMITTEE: A group of HP Enterprise Services Directors and Bureau of TennCare Executives who are responsible for providing guidance on overall strategic direction and guidance on key issues.

SUBCONTRACTOR: A party contracting with the Contractor and approved by the Bureau to perform services for the Bureau.

SUR: Surveillance and Utilization Review.

SURS: Surveillance and Utilization Review Subsystem.

TAD: Turnaround Document. Long term care Level One nursing facilities as well as HCBS and PACE (TennCare portion of capitation payments) provider services are currently billed to TennCare via this method.

TBI: Tennessee Bureau of Investigation.

TC: TennCare.

TCA: Tennessee Commission on Aging.

T.C.A.: Tennessee Code Annotated.

TCIS: TennCare Information Systems, referenced as an entity of the Bureau's management of the TCMIS.

TCMIS: TennCare Management Information System.

TDHS: Tennessee Department of Human Services, also referred to as DHS.

TDM: Technical Delivery Manager.

TDMR: Tennessee Division of Mental Retardation Services.

TDTM: Technical Delivery Team Manager.

TEMA: Tennessee Emergency Management Agency.

TEAMTRACK: Bureau of TennCare Change Management tracking software (Serena®TeamTrack®) or such other State approved change management system as the State may require.

TENNCARE: Tennessee Medicaid program under a 1115 waiver to the Social Security Act.

TENNCARE LAWSUITS: There are three (3) primary, federal class action lawsuits that have a direct impact on the business rules and operations of the TennCare Program. The lawsuits are:
DANIELS - this lawsuit was filed against the State in 1979 for noncompliance with Medicaid laws and regulations relating to due process and appeal rights of persons on Medicaid. Current State rules provide for an enrollee's appeal and hearing rights when services are denied, delayed, terminated, reduced or suspended, as well as for the enrollee's entitlement to a written decision on appeal within ninety (90) days for a standard appeal or thirty-one (31) days for an expedited appeal. It requires that an annual letter be sent to all TennCare enrollee's advising them of their appeal rights.
GRIER - is a 1999 federal class action lawsuit, resulting from the Daniels lawsuit. The consent decree expands the definition of what an enrollee can appeal. An enrollee may appeal an "adverse action" which is a denial, delay, termination, reduction or suspension of a TennCare benefit or any other act or omission that impairs the quality or timeliness of such benefit. A doctor's prescription is no longer needed to appeal. The consent decree provides for a fourteen (14) day supply of drugs and prohibits the Bureau of TennCare from terminating eligibility except for enrollees known to be living out-of-state or due to death.
ROSEN - this case was filed on behalf of persons eligible for TennCare as part of the expansion population in 1998, challenging the State's policies and procedures for determining and terminating TennCare eligibility. The major issue in the lawsuit was whether applicants and enrollees received appropriate due process, including the right to a hearing in such determinations.

TITLE VI: Civil Rights Act of 1964 that prohibits discrimination in federally assisted programs based on race, color, or national origin.

TITLE VII: Civil Rights Act of 1964 that prohibits discrimination under any equal employment opportunity law or order.

TITLE XVIII: Medicare health insurance component of the Social Security Act covering hospitalization (Part A) and medical (Part B).

TITLE XIX: The medical federal assistance program (Medicaid) as described in Title XIX of the Social Security Act.

TN KIDS: System maintained by DCS that is used to derive the DCS files.

TO-BE: The desired level of MITA.

TPL: Third Party Liability.

TPW: Tennessee Prison for Women.

TSU: Bureau of TennCare TennCare Solutions Unit for appeals and grievances.

TTS: Text-To-Speech Server used in AVRS.

TRANSLATOR: An application program designed to convert one (1) electronic format, in particular the HIPAA X12N standard transactions, into another format and perform additional data conversion if desired. TCMIS uses Sybase.

TWISS: Tennessee Welfare Integrated Services System.

UAT: User Acceptance Testing.

UCR: Usual and Customary and Reasonable rates.

UML: Unified Modeling Language

UPIN: Universal Provider Identification Number.

UPS: Uninterruptible Power Source.

U.S.C.A.: United States Code Annotated.

VA: United States Veteran's Administration.

VCTL: Version Control.

VENDOR: Any responsible source that provides a supply or service.

VIP: Vision Integration Platform, new Tennessee DHS eligibility system.

VPN: Virtual Private Network.

WAN: Wide area network.

WBS: Work Breakdown Structure.

WBT: Web Based Training.

WEDI SNIP: Workgroup for Electronic Data Interchange Strategic National Implementation Process.

WORK PLAN: Document identifying the tasks to be performed and the timeline for each task

WP: Work Planner.

WR: Work Request - A maintenance request for the TCMIS, a non-billable function.

WORK REQUEST: A maintenance request for the TCMIS, a non-billable function.

WORKFORCE MEMBER: Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity.

WORKING DAY: State workday. A "day" is defined as a minimum of eight (8) hours of service.

W3C: World Wide Web Consortium.

X12: An ANSI-accredited group that defines EDI standards for many American industries, including health care insurance. Most of the electronic transaction standards proposed under HIPAA are X12 standards.

X12 997: Functional Acknowledgement EDI transaction.

XML: Extensible Markup Language.

1610: Eligibility format from DHS.

GENERAL ASSEMBLY OF THE STATE OF TENNESSEE
FISCAL REVIEW COMMITTEE

320 Sixth Avenue, North – 8th Floor
NASHVILLE, TENNESSEE 37243-0057
615-741-2564

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Senators
Douglas Henry — Reginald Tate
Doug Jackson — Ken Yager
Paul Stanley
Randy McNally, *ex officio*
Lt. Governor Ron Ramsey, *ex officio*

Rep. Charles Curtiss, Vice-Chairman
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Mary Pruitt — Eddie Yokley
Craig Fitzhugh, *ex officio*
Speaker Kent Williams, *ex officio*

MEMORANDUM

TO: The Honorable Dave Goetz, Commissioner
Department of Finance and Administration

FROM: Bill Ketron, Chairman, Fiscal Review Committee
Charles Curtiss, Vice-Chairman, Fiscal Review Committee

BK
CC

DATE: June 23, 2009

SUBJECT: **Contract Comments**
(Fiscal Review Committee Meeting 6/22/09)

RFS# 318.66-022
Department: Finance & Administration/Bureau of TennCare
Contractor: Electronic Data Systems, LLC
Summary: The proposed four-year contract is for the provision of the operation, modifications, and enhancements of the TennCare Management Information System (TCMIS). The proposed contract has a term beginning July 1, 2009, and ending June 30, 2013, with the option to extend in a one-year increment for a total of five years, with a maximum liability of $170,662,054.
Maximum liability: $170,662,054

After review, the Fiscal Review Committee members present unanimously recommended approval of the contract. The Committee did not formally adopt the recommendation due to absence of a quorum. The recommendation will be presented for ratification at the next Committee meeting.

cc: The Honorable Darin Gordon, Deputy Commissioner
Mr. Robert Barlow, Director, Office of Contracts Review

STATE OF TENNESSEE
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

June 4, 2009

RECEIVED
JUN 08 2009
FISCAL REVIEW

Mr. Jim White, Director
Fiscal Review Committee
8th Floor, Rachel Jackson Bldg.
Nashville, TN 37243

Attention: Ms. Leni Chick

Dear Mr. White:

The Department of Finance and Administration, Bureau of TennCare, is submitting for consideration by the Fiscal Review Committee, Amendment #20 to Volunteer State Health Plan, Inc., Amendment #22 to Premier Behavioral Health Systems of Tennessee, LLC; and a new contract with Electronic Data Systems, LLC.

Amendment #20 to Volunteer State Health Plan (TennCare Select) is for the continuation for an additional year of medical services currently being provided by the contractor to children in state custody as well as other high risk TennCare enrollees. In addition to extending the contract for an additional year, the amendment also includes language integrating behavioral health services, to begin September 1, 2009, to be provided to the population sectors covered by TennCare Select.

Premier Behavioral Health Systems is the current contractor for the provision of behavioral health services for TennCare Select enrollees. This amendment will extend the term dates of the current contract with Premier for an additional two months to provide transition of behavioral health services to TennCare Select, who will assume the provision of integrated medical and behavioral health services on September 1, 2009. Additionally, the amendment provides funding and payment methodology to support the term extension.

Finally, the Bureau of TennCare is seeking approval to enter into a new contract with Electronic Data Systems (EDS) for the operation and enhancement of the TennCare Management Information Systems (TCMIS), including eight enhancements that will be implemented and operationalized over the next two years and two assessments that will

evaluate the Bureau's capabilities pertaining to Management and Administrative Reporting and the remediation needs for ICD10 implementation.

The Bureau of TennCare would greatly appreciate the consideration and approval of this contract and amendments by the Fiscal Review Committee.

Sincerely,

Scott Pierce
Chief Financial Officer

cc: Darin J. Gordon, Deputy Commissioner
Alma Chilton, Contract Coordinator

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Scott Pierce	*Contact Phone:	507-6415
*Contract Number:	N/A New Contract	*RFS Number:	318.65-080
*Original Contract Begin Date:	July 1, 2009	*Current End Date:	June 30, 2013
Current Request Amendment Number: *(if applicable)*	N/A		
Proposed Amendment Effective Date: *(if applicable)*	N/A		
*Department Submitting:	Department of Finance and Administration		
*Division:	Bureau of TennCare		
*Date Submitted:	June 4, 2009		
*Submitted Within Sixty (60) days:	No		
If not, explain:	TennCare released a Request for Proposal to identify a contractor for the operation and enhancement of the TennCare Management Information System. The winning proposal and subsequent contractor was ACS State Healthcare, however, due to mutual agreement between TennCare and ACS, the contract was terminated. The only other company who submitted proposal to the RFP was Electronic Data Systems (EDS). To ensure this contract provide immediate continuation of very critical services to TennCare with an effective date of July 1, 2009, time constraints prevented TennCare from submitting documentation to Fiscal Review in time to meet the sixty (60) day requirement.		
*Contract Vendor Name:	Electronic Data Systems Corporation, LLC		
*Current Maximum Liability:	$170,662,054.00		

*Current Contract Allocation by Fiscal Year:
(as Shown on Most Current Fully Executed Contract Summary Sheet)

N/A					

*Current Total Expenditures by Fiscal Year of Contract:
(attach backup documentation from STARS or FDAS report)

N/A					

IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:	N/A
IF surplus funds have been carried forward, please give the reasons and provide the authority for the carry forward provision:	N/A

Supplemental Documentation Required for Fiscal Review Committee

IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:	N/A			
*Contract Funding Source/Amount:	State:	$43,954,664.00	Federal:	$126,707,390.00
Interdepartmental:			*Other*:	
If "*other*" please define:				
Dates of All Previous Amendments or Revisions: (*if applicable*)		Brief Description of Actions in Previous Amendments or Revisions: (*if applicable*)		
N/A		N/A		
Method of Original Award: (*if applicable*)		Non Competitive		

Supplemental Documentation Required for Fiscal Review Committee

(1) **A detailed breakdown of the actual expenditures anticipated in each year of the contract, including specific line items, the source of funds (federal, state, or other--if other, please specify source), and the disposition of any excess funds.**

Actual expenditures are based on pricing mechanism as reflected in Section C.3 of the contract (attached as Attachment A).

Funding source is as follows:

50% State/50% Federal - General Administration

25%/State/ 75% Federal - Facility Management

10% State/ 90% Federal - Development (DDI)

(2) **A detailed breakdown in dollars of any savings that the department anticipates will result from this contract, including but not limited to, reduction in positions, reduced equipment costs, travel, or any other item related to the contract.**

The state of Tennessee has always contracted with an outside vendor to perform the Medicaid Managed Information Systems for the Bureau of TennCare. We are required by the Center for Medicare and Medicaid Services to have these services performed. There is only one state that performs these services in-house; all others are performed by outside vendor specializing in the management and operation of Medicaid information system. No reduction in positions, reduced equipment costs, travel, etc., will occur related to this contract, however, due to the fact that these services have always been performed by an outside vendor, no increase in costs will be associated with it.

(3) **A detailed analysis in dollars of the cost of obtaining this service through the proposed contract as compared to other options.**

There is not another viable option to perform these MMIS services. Only one other Medicaid program performs these services in-house.

Supplemental Documentation Required for Fiscal Review Committee

Attachment A

C.3. Payment Methodology:

The Contractor shall be compensated based on the payment rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1.

a) The Contractor's compensation shall be contingent upon the satisfactory completion of units, milestones, or increments of service defined in Section A.

b) The Contractor shall be compensated for said units, milestones, or increments of service based upon the rates as defined in Section C.3.

c) Pass-Through Cost Payments—The State shall reimburse the Contractor for pass-through costs pre-approved by the State, on the basis of actual cost. Pass-through costs shall not include any overhead, administrative, or other fee or commission. The Contractor shall petition the State for a reimbursement of pass-through costs on a monthly basis, in addition to the regular invoice for professional services provided pursuant to this Contract. The monthly petition for reimbursement of pass-through costs shall include substantiating documentation and the pre-approval by the State. Services reimbursed on a pass-through basis include postal related (i.e., postal services, postage and postal supplies); and third party vendor services (i.e., translation, Edifecs, SunGard, Avaya, and First DataBank). Contractor shall make payment to the Bureau approved postal carrier (the US Postal Service) or the administrator of the Bureau postage meters (the US Postmaster and Pitney Bowes) on behalf of the Bureau; however, the Contractor shall have no responsibility for the delivery by the postal carrier to an addressee. Invoicing for postage meters shall be based on the funds paid to replenish the meter, less a credit for any Contractor postage in the prior period. Pass-through postage costs do not include Contractor postage for Contractor business operations.

d) Professional Service Payments—The State shall compensate the Contractor based on the Service Rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1.

e) Special Projects Staffing compensation shall be based on the Payment Rates detailed in the Contractor's excess staffing proposal multiplied by the units of service authorized by the Bureau. The Bureau shall compensate the Contractor for Project work based on the hourly rates detailed in the Contractor's excess staffing proposal. The Contractor shall submit monthly invoices, in form and substance agreed to with the Bureau with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall, at a minimum, include the name of each individual, the individual's job title, the number of hours worked during the period, the applicable Payment Rate, the total compensation requested for the individual, and the total amount due the Contractor for the period invoiced.

f) Hardware, Software and Maintenance – The State may request the contractor purchase licenses or maintenance for hardware and software for the TCMIS. The State shall reimburse the Contractor for hardware and software products and maintenance purchased by request of the State based on the actual cost plus an administrative fee in the amount of twenty-one percent (21%) of the actual cost. The Contractor shall petition the State for

a reimbursement of maintenance costs on a monthly basis, in addition to the regular invoice for professional services provided pursuant to this Contract, and any and all amendments thereto. The monthly petition for reimbursement of maintenance costs shall include substantiating documentation.

The Contractor shall submit invoices no more often than monthly, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Such invoices shall be submitted for completed project milestones for the amount stipulated.

C.3.1. Assessment Pricing Details

The Contractor shall be compensated "per assessment/deliverable" during the Transition and Implementation Phase of this Contract. The Contractor shall be compensated in accordance with the fixed prices for each assessment/deliverable set forth in this Contract listed in the table labeled "Transition and Implementation Pricing Detail". Total Transition and Implementation Fixed Prices shall factor in all related costs and overhead (e.g., Salaries & Benefits, Travel, Administrative Overhead).

Assessment Pricing Detail Table follows:

Item #	Line Item Description	Fixed Price
1	Assessment 1 – MAR Assessment Section A.2.1.1	$142,881
2	Assessment 2 – ICD-10 Assessment Section A.2.1.2	See Below

ICD-10 Design (further defined in A.2.1.2) reimbursement shall be based on the Payment Rates detailed in C.3.4 Excess Staffing for units of service authorized by the State. The Contractor shall submit monthly invoices, in form and substance agreed to with the State with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall, at a minimum, include the name of each individual, the individual's job category, the number of hours worked during the period, the applicable Payment Rate, the total compensation requested for the individual, and the total amount due the Contractor for the period invoiced.

The maximum total fees for ICD-10 Design shall be one million one hundred thousand ninety eight thousand and nine hundred thirty eight dollars ($1,198,938.00). The Bureau may roll any residual funds that are unused for Phase 1 to ICD-10 Remediation (Phase 2) construction, configuration, testing and deployment activities.

C.3.2. Pricing of Major System Enhancements

The Contractor shall be compensated "per enhancement" to complete the TCMIS System Enhancements shown in the Request for Proposals. The Contractor shall be compensated in accordance with the fixed prices for each enhancement set forth in the Contract listed in the table labeled, Pricing of TCMIS System Enhancements. Total Enhancement Fixed Prices will already factor in all related costs and overhead (e.g., Salaries & Benefits, Travel, and Administrative Overhead).

Pricing of TCMIS System Enhancements

Item #	Line Item Description	*Fixed Price

Supplemental Documentation Required for Fiscal Review Committee

Item #	Line Item Description	*Fixed Price
E1	CMMI Level 2 Appraisal (Contract Section A.2.3)	
	Total Enhancement #1	$1,152,723
E1.1	CMMI Level 3 Appraisal (Contract Section A.2.3)	
	Total Enhancement #1.1	$1,353,196
E2	Technology Modernization (Contract Section A.2.4)	
	Total Enhancement #2	$4,681,343
E3	Implement PMO (Contract Section A.2.5)	
	Total Enhancement #3	$1,003,102
E4	Implement a COTS Dashboard (Contract Section A.2.6)	
	Total Enhancement #4	$553,840
E5	Implement a COTS Documentation software (Contract Section A.2.7)	
	Total Enhancement #5	$2,145,937
E6	Implement Enhanced Test Environment (Contract Section A.2.8)	
	Total Enhancement #6	$2,017,656
E7	Conduct Business Process Improvement (Contract Section A.2.9)	
	Total Enhancement #7	$2,530,716
E8	Implement Long-Term Care CHOICES (Contract Section A.2.10)	
	Total Enhancement #8	See Below

Enhancements #1 and #1.1 monthly invoices shall be in an amount equal to the maximum amount per enhancement detailed above divided by the number of calendar months in the subject period. The Bureau shall require retention of payment in the amount equal to fifteen percent (15%) of each monthly invoice for Enhancements #1 and #1.1. This retention of payment shall be held until the satisfaction of the final deliverable of the certification objective for that enhancement.

Enhancement #2 reimbursement shall be the maximum amount detailed above and allocated to the Bureau's acceptance of the following key deliverables, as follows.

1. Infrastructure Enhancements Installed (A.2.4.4.3 and A.2.4.4.4) = $2,955,125
2. Data Warehouse Enhancements Installed (A.2.4.4.5) = $1,631,763
3. Oracle Financial Transition Plan Accepted (A.2.4.4.6) = $17,870
4. Security Risk Assessment Accepted (A.2.4.4.7) = $ 76,585

Enhancement #3 reimbursement shall be made in lump sum on acceptance by the State of the base PMO standards, structures and staffing.

Enhancements # 4, #5 and #6 shall be made in lump sum upon acceptance by the State and implementation in production.

Enhancement #7 reimbursement shall be in an amount equal to the maximum amount for this enhancement detailed above divided by the number of MITA key business areas targeted by this enhancement, as referenced in A.2.9 and confirmed by the Bureau in the project planning process. Reimbursement for each business area shall be payable upon Bureau acceptance of the plan for the business processes, including mutually agreed upon process transformations and internal publication of the associated process documentation.
Enhancement #8 reimbursement shall be based on the Payment Rates detailed in C.3.4 Excess Staffing for units of service authorized by the State. The Contractor shall submit monthly invoices, in form and substance agreed to with the State with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall, at a minimum, include the name of each individual, the individual's job category, the number of hours worked during the period, the applicable Payment Rate, the total compensation requested for the individual, and the total amount due the Contractor for the period invoiced. The maximum total fees for Long-Term Care (LTC) CHOICES shall be one million nine hundred eighty six thousand two hundred fifty one dollars ($1,986,251.00). The Bureau may roll any residual funds that are unused for LTC CHOICES to ICD-10 Remediation (Phase 2) construction, configuration, testing and deployment activities.
C.3.3. Operations Costs (TCMIS)
Pricing Schedule C1, Item #1 indicates the contracted base rate for operations of the TCMIS, excluding enhancements. Operations compensation shall be based on the Base Rate amounts detailed below for units of service authorized by the State. The Contractor shall submit monthly invoices, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Said monthly invoices shall be in an amount equal to the maximum amount per period detailed below divided by the number of calendar months in the subject period (the divisor shall be twelve (12) after the first period of service).
If, for any reason, the Contractor does not fully meet the operational start date for any of the TCMIS processes and a Contract amendment delaying this date or start-up of a portion of the processing requirements listed has not been approved, then the Contractor shall be liable for costs incurred by the Bureau to continue current operations. Additionally, the Contractor shall forfeit any claims to reimbursement of monthly operations payments for that month and each month thereafter until the Bureau approves operational readiness.
Pricing Schedule C2, Item #1 indicates the contracted incentive rate. The incentive payment shall be paid based on the Contractor receiving a Quality and Customer Service score greater than or equal to eighty-six (86). The Contractor shall receive one hundred percent (100%) of the incentive payment for scores above ninety-three (93). However, the Contractor shall only receive a fifty percent (50%) incentive payment for scores between eighty-six (86) and ninety-three (93).
Pricing schedule C3, Items E1 – E7 shall indicate the contracted rates, if any, for the ongoing operational costs that may be expected for each of the enhancements.

Pricing Schedule C1
Operations Costs – Base Rate (TCMIS)

Supplemental Documentation Required for Fiscal Review Committee

		Fixed Cost				
Item #	Line Item Description	Operational Year 1 (7/1/2009 – 06/30/2010)	Operational Year 2 (7/1/2010 – 06/30/2011)	Operational Year 3 (7/1/2011 – 06/30/2012)	Operational Year 4 (7/1/2012 – 06/30/2013)	Average
1	Base Rate	$22,270,718	$22,424,491	$23,029,219	$23,662,012	$22,846,610

Pricing Schedule C2
Operations Costs – Incentive Rate (TCMIS)

		Fixed Cost				
Item #	Line Item Description	Operational Year 1 (7/1/2009 – 06/30/2010)	Operational Year 2 (7/1/2010 – 06/30/2011)	Operational Year 3 (7/1/2011 – 06/30/2012)	Operational Year 4 (7/1/2012 – 06/30/2013)	Average
1	Incentive Rate	$3,300,000	$3,300,000	$3,500,000	$3,500,000	$3,400,000

Supplemental Documentation Required for Fiscal Review Committee

Pricing Schedule C3

Operations Costs – Enhancement Operations (TCMIS)

		Fixed Cost			
Item #	Line Item Description	Operational Year 1 (7/1/2009 – 06/30/2010)	Operational Year 2 (7/1/2010 – 07/30/2011)	Operational Year 3 (7/1/2011 – 06/30/2012)	Operational Year 4 (7/1/2012 – 06/30/2013)
E1	Operations costs associated with maintaining CMMI Level 2 Appraisal	$0	$0	$0	$0
E1.1	Operations costs associated with maintaining CMMI Level 3 Appraisal	$0	$0	$0	$0
E2	Operations costs associated with Technology Modernization		$2,400,000	$2,472,000	$2,546,160
E3	Operations costs associated with PMO	$443,012	$547,563	$563,990	$580,909
E4	Operations costs associated with the COTS Dashboard	$0	$283,660	$292,169	$300,934
E5	Operations costs associated with the COTS Documentation software	$0	$30,258	$31,165	$32,100
E6	Operations costs associated with the Enhanced Test Environment	$21,409	$132,307	$136,276	$140,364
E7	Operations costs associated with Business Process Improvement	$0	$0	$158,190	$162,936
E8	Operations costs associated with LTC CHOICES	$0	$0	$0	$0

C.3.4. Special Projects Staffing

Supplemental Documentation Required for Fiscal Review Committee

Staffing for Special Projects (further defined in Contract Section A.6) compensation shall be based on the Payment Amounts detailed below for any staffing needs in excess of the contracted staffing levels, as authorized by the Bureau. The State shall compensate the Contractor for Change Order work based on the hourly rates below, in a total amount for each change request not to exceed the written estimate agreed upon by the State and the Contractor. The Contractor shall submit invoices no more often than monthly, in form and substance agreed to with the Bureau with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall be submitted for completed units of service for the amount stipulated. NOTE: The Contractor shall not be compensated for travel time to the primary location of service provision.

CATEGORY	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE
	7/01/2009 - 6/30/2010	7/01/2010 - 6/30/2011	7/01/2011- 6/30/2012	7/01/2012 - 6/30/2013
Information Specialist - Senior	$103.56	$106.67	$109.87	$113.16
Information Specialist	$80.00	$82.40	$84.87	$87.42
Information Analyst	$57.14	$58.85	$60.62	$62.44
Information Associate	$52.08	$53.64	$55.25	$56.91
Business Services Analyst - Senior	$71.56	$73.71	$75.92	$78.20
Business Services Analyst - Advanced	$60.72	$62.54	$64.42	$66.35
Business Services Analyst	$55.00	$56.65	$58.35	$60.10
Technical Delivery Team Manager	$91.93	$94.69	$97.53	$100.45
Project Manager	$95.75	$98.62	$101.58	$104.63
Project Analyst - Senior	$85.00	$87.55	$90.18	$92.88
Project Analyst - Advanced	$75.00	$77.25	$79.57	$81.95
Project Analyst	$65.00	$66.95	$68.96	$71.03
Data Base Administrator	$83.75	$86.26	$88.85	$91.52
Data Base Associate	$68.26	$70.31	$72.42	$74.59
Infrastructure Specialist Senior	$96.53	$99.43	$102.41	$105.48
Systems Administrator - - Advanced	$68.26	$70.31	$72.42	$74.59
Systems Administrator	$56.82	$58.52	$60.28	$62.09
Systems Administrator - Associate	$50.00	$51.50	$53.05	$54.64
Computer Operator	$35.00	$36.05	$37.13	$38.25
QA Specialist - Advanced	$70.00	$72.10	$74.26	$76.49
QA Specialist	$55.00	$56.65	$58.35	$60.10
Documentation Project Manager	$70.00	$72.10	$74.26	$76.49
Technical Writer	$45.00	$46.35	$47.74	$49.17
Specialized Support Clerk	$35.00	$36.05	$37.13	$38.25
General Support Clerk	$20.00	$20.60	$21.22	$21.85

Supplemental Documentation Required for Fiscal Review Committee

CATEGORY	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE
	7/01/2009 - 6/30/2010	7/01/2010 - 6/30/2011	7/01/2011- 6/30/2012	7/01/2012 - 6/30/2013
Change Management Coordinator	$65.00	$66.95	$68.96	$71.03
Release Coordinator	$65.00	$66.95	$68.96	$71.03
Work Planner	$65.00	$66.95	$68.96	$71.03

C.3.5. Excess Operations Transactions

Excess Operations Transactions compensation shall be based on the Payment Amounts detailed below for any transaction units in excess of the contracted requirement, as authorized by the Bureau. The Contractor shall submit invoices no more often than quarterly in form and substance agreed to with the State with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall be submitted for completed units of service for the amount stipulated.

TRANSACTION TYPE	FIXED FEE PER TRANSACTION			
	07/01/2009 06/30/2010	07/01/2010 – 06/30/2011	07/01/2011 – 06/30/2012	07/01/2012 – 06/30/2013
Suspense Transactions	$0.88	$0.88	$0.89	$0.89

Note:

Excess Suspense Transactions is defined as suspended claims needing resolution activities. Excess suspense transactions shall be determined when the number of suspended claims needing resolution exceeds an average of twelve thousand (12,000) per week for a twelve (12) week period. If the inventory exceeds this total, then the Contractor shall be eligible for reimbursement of excess operations and/or excess staffing that will be needed to facilitate these transactions. The Contractor shall provide sufficient supporting documentation to obtain Bureau approval for reimbursement of the excess transaction costs.

REQUEST: NON-COMPETITIVE CONTRACT

APPROVED
Commissioner of Finance & Administration Date:

Each of the request items below indicates specific information that must be individually detailed or addressed as required. A request can not be considered if information provided is incomplete, non-responsive, or does not clearly address each of the requirements individually as required.

1) RFS #	318.65-080
2) Procuring Agency :	Department of Finance and Administration Bureau of TennCare
3) Service Caption :	Operation and Enhancement of the TennCare Management Information System
4) Proposed Contractor :	Electronic Data Systems, LLC
5) Contract Start Date : (attached explanation required if date is < 60 days after F&A receipt)	July 1, 2009
6) Contract End Date: (if ALL options to extend the contract are exercised)	June 30, 2014
7) Total Maximum Cost: (if ALL options to extend the contract are exercised)	$170,662,054.00
8) Approval Criteria : (select one)	☒ use of Non-Competitive Negotiation is in the best interest of the state
	☐ only one uniquely qualified service provider able to provide the service

RECEIVED
JUN 0 8 2009
FISCAL REVIEW

9) Description of Service to be Acquired :

The Contract between the Bureau of TennCare and Electronic Data Systems (EDS) is for the operation and enhancement of the TennCare Management Information Systems. The operations phase of the EDS Contract requires EDS to increase their staffing levels to meet TennCare's system development demand, improved change management processes, policies, and procedures, and has more effective service level agreements linked to liquidated damages than the previous contract. The Contract also includes eight enhancements that will be implemented and operationalized over the next two years and two assessments that will evaluate the Bureau's capabilities pertaining to Management and Administrative Reporting and the remediation needs for ICD10 implementation.

The eight enhancements that the Bureau is requiring the Vendor to implement are as follows:

Enhancement #1 – Capability Maturity Model Integration (CMMI) – This Enhancement requires the Contractor to lead the effort in raising the TennCare capability maturity level to Level Two within twenty-four (24) months of the Contract start date and to Level Three within twenty-four (24) months of being appraised at Level Two.
Enhancement #2 – Technology Modernization – This Enhancement requires the Facilities Manager to support the Bureau's upgrade of specific hardware and software suites approaching end of life.
Enhancement #3 – Project Management Office (PMO) – This Enhancement requires the Contractor to create a PMO for coordinating the multiple aspects and projects within the TCMIS, and to follow the Project Management Body of Knowledge (PMBOK) guidelines for all changes, modifications, projects and enhancements.
Enhancement #4 – Commercial Off The Shelf (COTS) Dashboard – This Enhancement is to establish the use of a COTS dashboard software product (such as Crystal Xcelsius), that shall be used to report performance metrics and operations indicators.
Enhancement #5 – COTS Documentation Software – The Contractor shall secure and operate COTS documentation software with enhanced content management features and enhance Filenet, to be an enterprise-wide content management solution.

Enhancement #6 – Enhanced Testing Environment – The Contractor shall develop multiple integrated test environments with subsequent promotion to a full system test environment and finally promoted to a regression test environment prior to a production release. This shall require four (4) new test environments. The Contractor shall convert model office to the full systems test environment and the User Acceptance Test environment shall be converted to the regression test environment.
Enhancement #7 – Business Process Improvement – This Enhancement requires the Contractor to develop a complete and detailed business process model of the Bureau and Contractor business processes, and that this process modeling shall include Activity Based Costing.
Enhancement #8 – Long-Term Care CHOICES - This Enhancement requires the Contractor to support the Bureau's implementation of the Long-Term Care (LTC)

10) Explanation of the Need for or Requirement Placed on the Procuring Agency to Acquire the Service :

TennCare released a Request for Proposal to identify a contractor for the operation and enhancement of the TennCare Management Information System. The winning proposer and subsequent contractor was ACS State Healthcare, however, through mutual agreement this contract has been terminated. The Bureau of TennCare wishes to contract with the only other company who submitted proposal to the RFP, Electronic Data Systems (EDS).

11) Explanation of Whether the Procuring Agency Bought the Service in the Past, & if so, What Procurement Method It Used :

Yes. TennCare released a Request for Proposal; a contractor was identified and contract executed.

12) Name & Address of the Proposed Contractor's Principal Owner(s) : (not required for a TN state education institution)

Corporate CEO:

Mark Hurd
Hewlett-Packard Company
3000 Hanover Street
Palo Alto, CA 94304-1185 USA

13) Evidence of the Proposed Contractor's Experience and Length of Experience Providing the Service :

EDS has supported healthcare programs for more than 42 years, since the inception of both Medicare and Medicaid in 1965, with advanced claims processing systems and information management services. EDS provides services to Medicaid and Medicare programs, major pharmaceutical companies, other federal healthcare programs, insurance carriers, health maintenance organizations (HMOs), and employer corporations—affecting more than 124 million lives, making them the largest provider of Medicaid and Medicare process management services. EDS administers $88 billion in Medicaid benefits for more than 17 million recipients and $7 billion in Medicare benefits annually.

14) Office for Information Resources Endorsement : (required for information technology service; n/a to THDA)

Documentation is ... Not Applicable to this Request X Attached to this Request

15) eHealth Initiative Endorsement : (required for health-related professional, pharmaceutical, laboratory, or imaging service)

Documentation is ... ☒ Not Applicable to this Request ☐ Attached to this Request

16) Department of Human Resources Endorsement : (required for state employees training service)

Documentation is ... ☒ Not Applicable to this Request ☐ Attached to this Request

17) Description of Procuring Agency Efforts to Identify Reasonable, Competitive, Procurement Alternatives :

TennCare released a Request for Proposal to identify a contractor for the operation and enhancement of the TennCare Management Information System. The winning proposer and subsequent contractor was ACS State Healthcare, however, due to mutual agreement, this contract has been terminated and TennCare wishes to contract with the only other company who submitted proposal to the RFP, Electronic Data Systems (EDS). EDS was the incumbent contractor and has been providing, through a competitively bid contract, the operation of the TennCare Management Information System for several years.

18) Justification of Why the State Should Use Non-Competitive Negotiation Rather Than a Competitive Process :
(Being the "only known" or "best" service provider to perform the service as desired will not be deemed adequate justification.)

The Bureau of TennCare released a Request for Proposal to identify a contractor to to assume TennCare Management Information System (TCMIS) services. Due to a mutually agreed upon termination, it became necessary for TennCare to enter into an agreement with another provider of TCMIS services as expeditiously as possible. Electronic Data Systems (EDS) was the only other company who submitted a proposal to the RFP. In addition, EDS was the incumbent contractor and has been providing services in a transition role since the RFP was awarded. As such, entering into a Non-Competitive Negotiation with EDS would ensure the immediate continuation of services to TennCare enrollees.

REQUESTING AGENCY HEAD SIGNATURE & DATE :
(must be signed & dated by the ACTUAL procuring agency head as detailed on the Signature Certification on file with OCR— signature by an authorized signatory will be accepted only in documented exigent circumstances)

	6/2/09
Agency Head Signature	**Date**

081607

FAX/EMAIL TRANSMITTAL

to Request OIR Procurement Endorsement

TO :	Jane Chittenden, Director OIR Procurement & Contract Management	FAX # 741-6164
FROM :	Alma Chilton	FAX # 253-5414
DATE :	June 1, 2009	
RFS #	318.65-080	
RE :	Procurement Endorsement — Medicaid Management Information Systems	

INFORMATION SYSTEMS PLAN PROJECT: PROJECT NUMBER or N/A

NUMBER OF FAX PAGES (including cover) : N/A FOR EMAIL

The nature and scope of service detailed in the attached service procurement document(s) appears to require Office for Information Resources (OIR) review and support, because the procurement involves information technology or information systems services.

This communication seeks to ensure that OIR is aware of the procurement and has an opportunity to review the matter. Please determine whether OIR is supportive of the procurement. If you have any questions or concerns about this matter, please call **Alma Chilton at 507-6384.**

Please indicate below your response to this proposed procurement, and return this communication at your earliest convenience (note the return FAX number above).

Thank you for your help.

Attachment(s)

Must include the entire contract or amendment document and where applicable, the non-competitive contract or amendment request form. The original contract and any prior amendments that were applied to the same section of the contract must be provided with an amendment. Electronic copies of the contract, amendments, and request form without signature are acceptable.

RFP documents must be provided in electronic form.

OIR Endorsement : Approved for technical merit

OIR Chief Information Officer **Date** 6/5/09

CONTRACT SUMMARY SHEET

021908

RFS #	Contract #
318.65-080-10	FA-10-
State Agency	**State Agency Division**
Department of Finance and Administration	Bureau of TennCare
Contractor Name	**Contractor ID # (FEIN or SSN)**
Electronic Data Systems, LLC	☐ C- or ☒ V- 752548221 07

Service Description

Operation and Enhancement of the TennCare Management Information System

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
July 1, 2009	June 30, 2013	Vendor	93.778 Dept of Health & Human Services/Title XIX

Mark Each TRUE Statement

☒ Contractor is on STARS ☒ Contractor's Form W-9 is on file in Accounts

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
318.65	See Attached	083	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2010	$11,482,397.00	$38,569,908.00			$50,052,305.00
2011	$10,984,187.00	$31,312,155.00			$42,296,342.00
2012	$10,609,881.00	$28,011,737.00			$38,621,618.00
2013	$10,878,199.00	$28,813,590.00			$39,691,789.00
TOTAL:	$43,954,664.00	$126,707,390.00			**$170,662,054.00**

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
TOTAL:		
End Date:		

State Agency Fiscal Contact & Telephone #

Scott Pierce
310 Great Circle Road
Nashville, TN 37243
(615) 507-6415

State Agency Budget Officer Approval

Funding Certification (certification, required by T.C.A. § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)

Contractor Ownership (complete for ALL base contracts — N/A to amendments or delegated authorities)

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

Contractor Selection Method (complete for ALL base contracts — N/A to amendments or delegated authorities)

☐ RFP ☐ Competitive Negotiation * ☐ Alternative Competitive Method *
☒ Non-Competitive Negotiation * ☐ Negotiation w/ Government (ID, GG, GU) ☐ Other *

*** Procurement Process Summary** (complete for selection by Non-Competitive Negotiation, Competitive Negotiation, OR Alternative Method)

TennCare released a Request for Proposal to identify a contractor for the operation and enhancement of the TennCare Management Information System. The winning proposal and subsequent contractor was ACS State Healthcare, however, due to transition and performance issues, TennCare utilized termination language to cancel the ACS contract and contract with the only other company who submitted proposal to the RFP, Electronic Data Systems (EDS). EDS was the incumbent contractor and has been providing, through a competitively bid contract, the operation of the TennCare Management Information System for several years.

FUNDING REVISION

CONTRACT

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

Begin Date	End Date	Agency Tracking #	Edison Record ID
July 1, 2009	June 30, 2013	31865-00080	12056

Contractor Legal Entity Name	Edison Vendor ID
Electronic Data Systems, LLC (HP Enterprises)	68107

Service Caption (one line only)

FUNDING REVISION: $4,000,000.00 moved from FY 2012 50/50 Funding Split (Speed Chart TN00000138) to FY 2012 90/10 Funding Split (Speed Chart TN00000140) and $4,000,000.00 from FY 2013 50/50 Funding Split (Speed Chart TN00000138) to FY 2013 90/10 Funding Split (Speed Chart TN00000140) – See attached Contract Summary Sheet Supplemental

Subrecipient or Vendor

☐ Subrecipient ☒ Vendor

CFDA #

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2010	$11,482,397.00	$38,569,908.00			$50,052,305.00
2011	$10,984,187.00	$31,312,155.00			$42,296,342.00
2012	$9,009,881.00	$29,611,737.00			$38,621,618.00
2013	$9,278,199.00	$30,413,590.00			$39,691,789.00
TOTAL:	**$40,754,664.00**	**$129,907,390.00**			**$170,662,054.00**

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

Ownership/Control

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

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

☐ RFP	The procurement process was completed in accordance with the approved RFP document and associated regulations.
☐ Competitive Negotiation	The predefined, competitive, impartial, negotiation process was completed in accordance with the associated, approved procedures and evaluation criteria.
☐ Alternative Competitive Method	The predefined, competitive, impartial, procurement process was completed in accordance with the associated, approved procedures and evaluation criteria.
☒ Non-Competitive Negotiation	The non-competitive contractor selection was completed as approved, and the procurement process included a negotiation of best possible terms & price.
☐ Other	The contractor selection was directed by law, court order, settlement agreement, or resulted from the state making the same agreement with all interested parties or all parties in a predetermined "class."

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

Speed Chart (optional): See Attached

Account Code (optional): 70803000

OCR USE - FA

Contract # **FA1028520-00**

Funding Revision

CONTRACT SUMMARY SHEET SUPPLEMENT					
Edison #	12056				
Contract #	FA-10-28520-00				
Fiscal Year	2012				
Program Code	**Speed Chart**	**Account Code**	**Fund**	**CFDA #**	**Amount**
532085 (50/50)	TN00000138	70803000	11000	93.778	$4,162,972.00
REVISION					($4,000,000.00)
532085 (50/50)	**TN00000138**	**70803000**	**11000**	**93.778**	**$162,972.00**
532097 (75/25)	**TN00000139**	**70803000**	**11000**	**93.778**	**$33,883,538.00**
532109 (90/10)	TN00000140	70803000	11000	93.778	$575,108.00
REVISION					+$4,000,000.00
532109 (90/10)	**TN00000140**	**70803000**	**11000**	**93.778**	**$4,575,108.00**
					$38,621,618.00

Funding Revision

CONTRACT SUMMARY SHEET SUPPLEMENT					
Edison #	12056				
Contract #	FA-10-28520-00				
Fiscal Year	2013				
Program Code	**Speed Chart**	**Account Code**	**Fund**	**CFDA #**	**Amount**
532085 (50/50)	TN00000138	70803000	11000	93.778	$4,287,860.00
REVISION					($4,000,000.00)
532085 (50/50)	**TN00000138**	**70803000**	**11000**	**93.778**	**$287,860.00**
532097 (75/25)	**TN00000139**	**70803000**	**11000**	**93.778**	**$34,625,841.00**
532109 (90/10)	TN00000140	70803000	11000	93.778	$778,088.00
REVISION					+$4,000,000.00
532109 (90/10)	**TN00000140**	**70803000**	**11000**	**93.778**	**$4,778,088.00**
					$39,691,789.00

CONTRACT SUMMARY SHEET

021908

RFS #	Contract #
318.65-080-10	FA-10-28520-00
State Agency	**State Agency Division**
Department of Finance and Administration	Bureau of TennCare
Contractor Name	**Contractor ID # (FEIN or SSN)**
Electronic Data Systems, LLC	☐ C- or ☒ V- 752548221 07

Service Description

Operation and Enhancement of the TennCare Management Information System

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
July 1, 2009	June 30, 2013	Vendor	93.778 Dept of Health & Human Services/Title XIX

Mark Each TRUE Statement

☒ Contractor is on STARS ☒ Contractor's Form W-9 is on file in Accounts

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
318.65	See Attached	083	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2010	$11,482,397.00	$38,569,908.00			$50,052,305.00
2011	$10,984,187.00	$31,312,155.00			$42,296,342.00
2012	$10,609,881.00	$28,011,737.00			$38,621,618.00
2013	$10,878,199.00	$28,813,590.00			$39,691,789.00
TOTAL:	$43,954,664.00	$126,707,390.00			$170,662,054.00

OCR RELEASED
JUL 29 2009
TO ACCOUNTS

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
TOTAL:		
End Date:		

State Agency Fiscal Contact & Telephone #

Scott Pierce
310 Great Circle Road
Nashville, TN 37243
(615) 507-6415

State Agency Budget Officer Approval

Funding Certification (certification, required by T.C.A., § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)

Contractor Ownership (complete for ALL base contracts— N/A to amendments or delegated authorities)

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

Contractor Selection Method (complete for ALL base contracts— N/A to amendments or delegated authorities)

☐ RFP ☐ Competitive Negotiation * ☐ Alternative Competitive Method *
☒ Non-Competitive Negotiation * ☐ Negotiation w/ Government (ID, GG, GU) ☐ Other *

*** Procurement Process Summary** (complete for selection by Non-Competitive Negotiation, Competitive Negotiation, OR Alternative Method)
TennCare released a Request for Proposal to identify a contractor for the operation and enhancement of the TennCare Management Information System. The winning proposal and subsequent contractor was ACS State Healthcare, however, due to transition and performance issues, TennCare utilized termination language to cancel the ACS contract and contract with the only other company who submitted proposal to the RFP, Electronic Data Systems (EDS). EDS was the incumbent contractor and has been providing, through a competitively bid contract, the operation of the TennCare Management Information System for several years.

JUN 25 2009
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CONTRACT
BETWEEN THE STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AND
ELECTRONIC DATA SYSTEMS, L.L.C.

This Contract, by and between the State of Tennessee, Department of Finance and Administration, Bureau of TennCare, hereinafter referred to as the “State” or “Bureau” or “TennCare” and Electronic Data Systems, L.L.C., hereinafter referred to as the “Contractor,” is for the provision of the Operation, Modifications and Enhancement of the TennCare Management Information System, as further defined in the "SCOPE OF SERVICES."

The Contractor is A LIMITED LIABILITY COMPANY.

Contractor Vendor Identification Number: FEDERAL EMPLOYER ID #:

75-2548221

Contractor Address:

HP/EDS Legal
5400 Legacy Drive
Mail Stop H3-3A-01
Plano, TX 75024
Telephone #(972) 605-5484

Contractor Place of Incorporation or Organization:

Delaware, U.S.A

A. SCOPE OF SERVICES AND DELIVERABLES

The Contractor shall provide all services and deliverables as required, described, and detailed by this Scope of Services and shall meet all service and delivery timelines specified in the Scope of Services section, and any attachment or amendment thereto, or elsewhere in this Contract. TennCare may prioritize any contract requirement or deliverable as is necessary for the benefit of the Enrollees and the State.

Transition Requirements

The Contractor shall be responsible for continuing meet the existing requirements of the TennCare Management Information System (TCMIS).

Effective Date of the Contract / Modified Operations Start Date - Performance Requirement

Upon the Effective Date of the Contract, the Contractor shall have sufficient staff to operate the baseline system and business processes contained in the Contract. Baseline business processes shall mean to correctly process all claim types, claims adjustments, and other financial

transactions; maintain all system files; produce all required reports; and manage the day-to-day operations of the TCMIS in accordance with the Contract. The Bureau recognizes that staffing level is a key performance indicator for the Contractor and has established accountabilities for the Contractor to reach the higher staffing levels necessary to attain and sustain increased performance expectations. Upon the Modified Operations start date, the Contractor shall have sufficient staff to meet the higher standard in A.6.

It is the intent of TennCare to have the modified TCMIS fully operational on March 1, 2010, which is the Modified Operations start date. The transition from the baseline staffing levels on the Effective Date of the Contract to the higher staffing levels needed by the Modified Operations Start Date is critical to TennCare's interest and therefore time is of the essence. The Contractor shall be liable for resulting damages if this date is not met. The Contractor's capability to meet this date shall be periodically evaluated by TennCare on an on-going basis. If deficiencies are found through an evaluation, Control Memorandum(a) shall be issued to the Contractor detailing the deficiencies to be corrected. If the Contractor fails to meet performance requirements, TennCare may elect to initiate Liquidated Damages in accordance with Attachment B or to terminate the TCMIS Contract in accordance with Section E. TennCare approved extensions of deliverable due dates or requirements shall not constitute a waiver of this provision on the part of TennCare.

In addition to the increased staffing required to improve baseline systems and business processes, there shall be additional staffing requirements in the Contract related to the definition, design, construction, testing and implementation of Assessments and Enhancements.

General Scope of the TCMIS Project:

The Contractor agrees to perform the Facilities Management operations, modifications and Enhancements to the TCMIS under this Contract, and any and all amendments thereto, meeting all of the State's requirements in accordance with this Contract and Attachments.

A.1 TCMIS Project Management

A.1.1 Information Technology Methodology (ITM)

The Contractor shall utilize the State's Information Technology Methodology (ITM) in the transition, development and implementation of the TCMIS Start-up, Operations and Enhancements. The Project Management Processes are pertaining to organizing and controlling the work of the project. The Product Development Phases involve the construction of the product enhancements for the project. The Project Management Processes encompass the takeover and the development of enhancements. Throughout the project, the Contractor shall produce numerous Project Management Process and Product Development Phase deliverables. Some of these products are specific deliverables that shall be managed, produced, and updated by the Contractor. Others are natural work-products arising out of the shared effort of both parties. TennCare shall prepare and issue Control Memorandum(a) that shall contain the history, background, and any other pertinent information relative to the deliverable, report or change issue(s) being addressed. The Control Memorandum(a) shall detail the action to be taken by the Contractor.

The processes and phases are as follows:

A.1.1.1 Project Management Processes

a) Planning – Devise and maintain the "Project Plan" using input from the initiation of the project proposal to accomplish the business need.

b) Execution – Carry out the activities included in the "Project Plan" that includes developing the project team, coordinating activities, distributing information and verifying work results.

c) Controlling – Ensure project's objectives are met by monitoring and measuring its progress.

d) Quality Management – Identify quality policies, objectives, and responsibilities to be used for the project, and ensure that these are implemented and monitored throughout the term of the project.

e) Procurement Management – Acquire goods and services from vendors, contractors, and/or suppliers, and to manage the contracts that are established through contract completion.

f) Phase/Project Closure – Evaluate the aspects of the project's status, make go/no go decisions and obtains final project sign off.

A.1.1.2 Product Development Phases

a) Scope and Feasibility – Establish the high-level requirement and assess impacts, constraints and recommendations for the product to be developed.

b) Requirement Definition and Solution Evaluation – Establish detailed requirements and evaluate high-level solution alternatives for satisfying requirements.

c) Design – Design the product to a detailed level and provide the framework for constructing the product.

d) Construction – Build and test product components, integrate and test component assemblies, and prepare for acceptance testing.

e) Acceptance Test – Evaluate the ability of the product to satisfy all product requirements by the customer organization and obtain necessary signoff on the product.

f) Implementation – Complete product integration, train users, monitor product operation and update documentation as needed.

A.1.2 Project Management and Approach

A.1.2.1 State's Information Technology Methodology (ITM)

The Contractor shall utilize the State's ITM in the development of its approach to the TCMIS Project. Since the State's ITM is defined at a high-level for use on all types and sizes of information technology (IT) projects, the Contractor shall develop a detailed project management methodology within the guidelines of the State's ITM.

A.1.2.2 Access to the State's ITM

The State's ITM includes process definitions, guidelines, document deliverable templates, and tools that support two (2) basic categories of processes: (a) Project Management Processes, and (b) Product Development Methodology.

The Project Management Processes category describes the procedures for organizing and controlling the work of the project, which shall extend over one (1) or more Product Development Phases. The Product Development Phases describe the processes for developing the enhancements.

A.1.2.3 Change Order Process

A.1.2.3.1 In this Section, the State's Change Order Process is described for Contractor requirements and deliverables specific to the Bureau's needs and to comply with changes in State and Federal laws, regulations, and court orders that impact TennCare business processes.

Modified functionalities defined in this contract shall be managed using the Change Order Process. As required, monitoring of the new functions shall be accomplished by the creation of new reports and performance monitoring tools developed through the Change Order Process.

A.1.2.3.2 The Change Order management principles are as follows:

a) The project scope and any changes resulting in a Change Order, shall be reviewed with and approved by the appropriate Bureau leadership, in accordance with the Bureau's published change order approval procedures.

b) All project team members shall maintain commitment and adherence to the project scope.

c) All Change Orders shall be documented and submitted to the Bureau assigned Project Director who shall be a Bureau employee or designee and who shall be responsible for oversight of the Change Order process as outlined in this section.

A.1.2.3.3 Change Order Approach

As with project issues, proposed project Change Orders shall be reviewed, prioritized, assigned, and resolved. Change Order resolution differs from issue resolution such that there is an impact on project resources, timeline, and/or budget with a Change Order that shall require approval. Therefore, a justification for the Change Order shall be documented, including development of a cost analysis. Project changes that affect the business processes/system functionality or technical architecture and/or occur after the deliverable/product has been accepted shall be researched to determine the impact on the project. Frequently, these particular project issues shall require a Change Order.

A.1.2.3.4 Change Order Procedure

Following is a description of each step in the Change Order procedure:

a) Create & Log Change Order – The process shall be initiated by an issue being deemed a Change Order. The request shall specify the nature of the change and the business justification for the change (the justification may be preliminary and a further evaluation shall be performed as part of the process). A Change Order request at

the Bureau is referred to as either a Work Request (WR) or a System Change Request (SCR) and are tracked and monitored through the TeamTrack system.

b) Assign Ownership – Each Change Order request shall be assigned an owner by the Project Director (or his/her designee) who shall be responsible for performing an evaluation of the impact of the change on the project's budget.

c) Perform Impact Analysis – Each Change Order request shall be analyzed to determine its potential impact on the project's budget, resources and schedule within fifteen (15) calendar days of its submission. Costs, benefits, impact on quality, staffing and project risk, and the associated timing of each shall be evaluated and an analysis shall be prepared for presentation to the Project Steering Committee.

d) Obtain Approvals – The Cost/Benefit evaluation that shall be performed during the "Perform Impact Analysis" step in this process is presented to the Project Steering Committee who shall approve or reject the requested change.

e) Update Project Documentation – If the Change Order request is accepted and/or approved, project management shall move forward with implementing the change. All necessary project documentation shall be updated accordingly (e.g., project plan, risk assessment).

A.1.2.3.5 Change Order Escalation

If a Change Order is logged and properly documented and cannot be resolved within the normal channels or within the required timeframe, the Issue Escalation Process shall be initiated, as a Change Order request shall be treated the same as any other unresolved project issue. Please see the Issue Escalation Process in Section A.1.2.4.2.

A.1.2.4 Issue Resolution Process

The following issue resolution process shall be used during the Project:

Any issue that arises during the project that cannot be immediately resolved or requires a decision or action involving those outside the project team shall be documented and maintained in the Project Issues Log by the Contractor. Anyone on the TCMIS Project team may submit a new issue to the Issues Log. An issue may be a decision or question of any size, small or large, that concerns any part of the project. Only the Project Director (or his/her designee) may close an issue, to confirm resolution of the issue before it is no longer tracked.

The Issues Log allows management to review outstanding questions, decisions and pending actions, and provide guidance on those issues that are of the highest priority. The Issues Log shall also be a tool used to communicate all project issues to senior management and Executive Sponsors. If there is an impact on project resources, timeline, and/or budget, then the issue may also require a Change Order.

If an issue or a deficiency is identified, the following process shall be utilized.

Control Memorandum(a)

Control Memorandum(a) shall be utilized by TennCare for assessment and enforcing the existing Contract requirements that the Contractor shall satisfy when correcting an issue or implementing any instruction from TennCare. Both parties shall utilize Control Memorandum(a) to propose, approve, or implement changes to the Work Plans, Resource Level Staffing Plans, and any other changes to the TCMIS project. This process is not intended to replace the standard change

management process to accommodate modifications or to bypass processes for mutual agreement in negotiating changes in Contract scope and reimbursement. A Control Memorandum, accompanied by a Control Directive, as described below, shall be incorporated into the Contract when it is issued.

When TennCare becomes aware of a problem or a potential problem, the TennCare Project Director shall issue Control Memorandum(a) of its findings and recommendations and require the Contractor to comply with the Control Memorandum(a) as appropriate. The Contractor shall have adequate staffing and resources to develop and implement the Control Memorandum(a) requirements. Failure to complete or comply with Control Memorandum(a) as required by TennCare may result in sanctions including liquidated damages and possible termination of the Contract.

All Control Memoranda shall be reviewed and prioritized by the Project Director. All Control Memoranda submitted to the Contractor shall be signed and approved by the Project Director or the Project Director's designee.

Compliance Assessment Procedures

TennCare shall prepare and issue Control Memorandum(a) that shall contain the history, background, and any other pertinent information relative to the issue and/or issues being addressed in the Control Memorandum(a). TennCare shall include with the Control Memorandum(a) one of the following accompanying documents: 1) Control Directive; 2) On Request Report; 3) Potential Liquidated Damages Letter; or 4) Liquidated Damages Assessment Letter. These documents shall detail the action to be taken by the Contractor. Failure to complete or comply as required with the aforementioned documents may result in sanctions including liquidated damages for each day the documents are not completed or complied with as required.

One of the following documents shall be included with the issuance of Control Memorandum(a):

1. On Request Report (ORR) - a request issued by TennCare directing the Contractor to provide information by COB of an instructed reasonable due date. This document shall be treated as a request for information only, and shall not be used to direct that a given task be completed. For example, an ORR may be issued to request information on a potential compliance issue or to request a corrective action plan. As a second example, if a control directive that had been issued for a first draft of a Work Plan and the directive was not complied with by close-of-business of the instructed due date, the day after the due date an ORR would be issued requiring the Contractor to provide information on why the Work Plan was not delivered. Failure to complete or comply with an ORR may result in the assessment of liquidated damages in the amount of one hundred dollars ($100) per business day starting on the business day after the ORR due date. All due dates requested during this process shall be reasonable and shall not include weekends or holidays.

   Or

2. Control Directive - an instruction issued by TennCare that requires the Contractor to complete a certain deliverable by a certain reasonable due date. For example, TennCare may issue a Control Directive to the Contractor requiring a first draft of a Work Plan to be delivered to TennCare by close-of-business on the day of May 15. Failure to complete or comply with a Control Directive deliverable may result in the assessment of liquidated damages in the

amount of five hundred dollars ($500) per business day starting on the calendar day after the deliverable due date. This damage assessment shall not include weekends and holidays. Once a Control Directive has been issued, it shall be considered to be incorporated into this Contract.

Or

3. Potential Liquidated Damages Letter (PLD) - a letter issued by TennCare that notifies the Contractor that a Control Directive response or an ORR response is late, incorrect, or incomplete. This letter shall detail the days the Control Directive response or ORR response was late, incorrect, or incomplete and calculate those days with the applicable daily liquidated damages rate to determine the total potential liquidated damages that TennCare may assess against the Contractor.

   Or

4. Liquidated Damages Assessment Letter (LDA**) -** a letter issued by TennCare that notifies the Contractor that a Control Directive or an ORR response is late, incorrect, or incomplete. This letter shall detail the number days that the Directive response or ORR response was late, incorrect, or incomplete and calculate those days with the applicable daily liquidated damages rate to determine the total liquidated damages that TennCare assessed and shall withhold from the Contractor's next payment.

A.1.2.4.1 Issue Resolution Procedure

The steps for reporting and resolving a project issue shall be:

1) Submit Issue - All identified issues shall be entered into the Issues Log. An issue may be entered by anyone. The default issue status shall be "Submitted". Each issue shall be assigned to a category so that the category of issues can be tracked. Examples of issue categories may include, but are not limited to:

Functional – Broken out by functional module

Technical

Communications

Project Scope/Funding

Policy/Legal

Organizational

The log shall be updated as an issue continues to progress through the process.

2) Review and Prioritize Issue - The Project Director (his/her or designee) shall review a newly submitted issue and determine whether to accept/assign, reject, or defer the issue. Assigned issues shall be prioritized based on the impact the issues have, or shall have, on the project's progress, and the issues are assigned a target resolution date. For certain categories of issues, such as "Policy/Legal" or "Project Scope/Funding", those issues shall be immediately escalated to the Project Director (or his/her designee) to be resolved or further escalated, as these shall not be resolved at the project team level. Please refer to the Issue Escalation process in Section A.1.2.4.2. Project management shall closely monitor the Issues Log as certain unresolved issues may materially impede the progress of the project.

3) Assign Issue to an Owner - The Project Director (or his/her designee) shall assign an accepted issue to an owner who shall be responsible for driving the issue to resolution.

4) Evaluate Resolution Options - The issue owner shall determine and document viable resolution options, and then manage the evaluation of the options, taking into account the pros and cons of each option. The issue owner shall be responsible for collaborating with others, where necessary, to evaluate options and reach a resolution.

5) Resolve Issue - The issue owner shall work to resolve the issue by the target resolution date. The typical timeframes for resolving an issue shall be as follows:

High priority issue: three (3) days

Medium priority issue: seven (7) days

Low priority issue: ten (10) days

If the issue is not resolved by the target date, then the Project Director (or his/her designee) may choose to escalate the issue. The owner of the issue shall confer with project management to determine the appropriate management escalation action to take. See the Issue Escalation Process, as set forth in Section A.1.2.4.2.

6) Close Issue - Once an issue has been resolved, it shall be assigned a ”Closed” status by the Project Director (or his/her designee) in the Issues Log.

If an issue has not been resolved by its assigned target resolution date, then the issue may be automatically escalated. The first level of issue escalation shall be to the Project Director (or his/her designee). Types of issues that shall be escalated may include, but are not limited to:

Issues that are past their target resolution date and have an urgency to being resolved;

Issues that have a significant impact on the project or organization;

Issues that shall have a significant impact on project scope;

Issues that may result in additional cost to the State; and

Issues that may cause the project schedule to slip or for a deliverable to be critically late.

A.1.2.4.2 Issue Escalation Process

The Project Director (or his/her designee) may be able to resolve the issue at that level, and address the issue with the support of the original issue owner to reach resolution. If the Project Director (or his/her designee) is not able to resolve an issue within five (5) days, or if it is an issue that cannot be resolved at the Project Director level, the issue shall escalate to the TennCare Director or his/her designee(s) for consideration and final resolution.

A.1.3 Project Start-Up Approach

A.1.3.1 Start-Up Plan

The Contractor shall develop and submit to the Bureau a Start-Up Plan that shall address the Bureau’s desire to reduce risk during start-up of the TCMIS Project. The Contractor shall

maintain the TCMIS without interruption in beneficiary eligibility verification, provider enrollment, or claims payment. Maintenance of the Facilities Manager operations shall ensure there is no disruption to State and federal reporting activities.

The Bureau shall approve the content and format of all deliverables. The Bureau reserves the right to reject any deliverable that is not in the proper format or does not appear to completely address the function of the deliverable requirement.

The Contractor shall provide the following Start-Up Plan Deliverables:

A.1.3.1.1 Start-Up Plan, which is due no later than August 1, 2009.

A.1.3.1.2 Informal presentation to Bureau staff.

A.1.3.1.3 Business Continuity and Contingency Plan, in accordance with A.5.4, at least sixty (60) days prior to the Modified Operations Start Date.

A.1.3.1.4 Security Plan, in accordance with A.5.4, at least sixty (60) days prior to the Modified Operations Start Date.

A.1.3.1.5 Performance Reporting Plan, as agreed with the Bureau, at least ninety (90) days prior to the Modified Operations Start Date.

A.1.3.2 Start-Up Requirements Analysis

The Contractor shall conduct a Requirements Analysis to prepare for the Modified Operations to address all systems and shall not be limited to just the core TCMIS subsystems. The Contractor shall also produce Requirements Analysis documentation, in formats approved by the Bureau that identifies the requirements of this Contract that need clarification and the documented resolution agreed upon with the Bureau; and identifies requirements that differ from the TCMIS as transitioned and describes the plan to initiate change requests for Bureau prioritization

The Contractor shall provide the following Requirements Analysis Deliverables. Unless otherwise approved by the Bureau, failure to deliver these items as required may result in the assessment of liquidated damages in accordance with Attachment B.

A.1.3.2.1 Requirements Analysis which is due no later than October 1, 2009.

A.1.3.2.2 Revised Operating Procedures, which is due no later than February 1, 2010.

A.1.3.2.3 Presentation of Requirements Analysis to Bureau staff.

A.1.3.3 Start-Up Staffing Plan

The Contractor shall prepare the Staffing Plan, which shall contain an initial list of Key Personnel and number of staff the Contractor has assigned to the TCMIS project and a description of the Contractor's project organization, including workflow and procedures required by this Contract.

The Contractor shall provide Key Personnel, who shall have previous experience of providing quality work on projects of similar scope and size, to ensure a successful start-up of the TCMIS. The general responsibilities, minimum qualifications, and expected start date for these Key

Personnel are included in the Staffing Section A.6. The number of key staff required and general staff requirements are also listed in Section A.6.

The Contractor shall provide sufficient staff, both on-site and elsewhere, to accomplish all tasks identified in the Contract. The Contractor shall provide experienced, qualified professionals to ensure the success of this project. The State expects the Contractor to develop a Staffing Plan that shall define the Contractor's approach for meeting the staffing requirements.

The Contractor shall provide the following Staffing Plan Deliverables. Unless otherwise approved by the Bureau, failure to deliver these items as required may result in the assessment of liquidated damages in accordance with Attachment B.

A.1.3.3.1 Staffing Plan, which is due no later than September 1, 2009.

A.1.3.3.2 Training Plan, which is due no later than September 1, 2009.

A.1.3.3.3 Informal presentation of Staffing Plan to Bureau staff.

A.1.3.4 Start-Up Work Plan

The Contractor shall submit a formal Start-Up Work Plan that shall adhere to required and standard Work Breakdown Structure (WBS).The project Work Plan shall be used by the Bureau as a tool to monitor the progress of all tasks. The Contractor shall clearly define each task and specify a target completion date for each activity. Any changes from current operating procedures shall be clearly identified and reflected in other sections of the document.

The Contractor shall provide the following Work Plan Deliverables. Unless otherwise approved by the Bureau, failure to deliver these items as required may result in the assessment of liquidated damages in accordance with Attachment B.

A.1.3.4.1 Work Plan, which is due no later than August 1, 2009.

A.1.3.4.2 Informal presentation to the Bureau.

A.1.3.5 Start-Up Configuration Management Strategic Plan

The Contractor shall submit a Configuration Management strategic plan that outlines the high-level flow, tools and controls used at Start-Up.

The Contractor shall provide the following Configuration Management Strategic Plan Deliverables. Unless otherwise approved by the Bureau, failure to deliver these items as required may result in the assessment of liquidated damages in accordance with Attachment B.

A.1.3.5.1 Configuration Management Strategic Plan, which is due no later than September 30, 2009.

A.1.3.5.2 The Configuration Management Plan shall include the Contractor's version management strategy.

A.1.3.5.3 The Configuration Management Plan shall include the Contractor's build management strategy.

A.1.3.5.4 The Configuration Management Plan shall include the Contractor's release management strategy.

A.1.3.5.5 The Configuration Management Plan shall include the Contractor's change management strategy.

A.1.4 Independent Verification and Validation

Independent Verification and Validation (IV&V) is a set of Verification and Validation activities performed to analyze Start-Up, Assessment and Enhancement activities by an entity that is not under the control of the Contractor. The Bureau shall select an IV&V Services Vendor that shall be technically, managerially and financially independent of the Contractor who shall check that the software provided by the Contractor meets the users' needs (Validation) and check that the system is well engineered (Verification). During the active phase of IV&V, the IV&V Vendor shall be acting with the full authority of the Bureau in performing its evaluation activities.

The selected IV&V Vendor shall be required to perform the following series of Verification and Validation tasks. The Contractor shall be required to provide access to systems, data, personnel, and documentation as appropriate to support these activities.

1) Project Management

The IV&V Vendor shall evaluate project progress, resources, budget, schedules, work flow, and reporting. The IV&V vendor shall provide oversight management of the Project Management Plan created by the Contractor to ensure the plan is being followed, evaluate the effectiveness of the plan to keep the project on schedule, and review the Contractor's associated reporting.

2) Quality Management

The IV&V Vendor shall evaluate project progress, resources, budget, schedules, work flow, and reporting. The vendor shall monitor the Project Management Plan created by the Contractor to ensure the plan is being followed, evaluate the effectiveness of the plan to keep the project on schedule, and review the Contractor's associated deliverables and reporting.

3) Requirements Management

The IV&V Vendor shall evaluate and make recommendations on the project's process and procedures for managing requirements.

4) Operating Environment

The IV&V Vendor shall evaluate and make recommendations on new and existing system hardware configurations to determine if their performance is adequate to meet current and future system requirements.

5) Development Environment

The IV&V Vendor shall evaluate and make recommendations on new and existing development hardware configurations to determine if their performance is adequate to meet the needs of system development.

6) Training

The IV&V Vendor shall review training and make recommendations on the training provided to system users. This shall include verifying sufficient knowledge transfer for maintenance and operation of the system.

7) System and Acceptance Testing

The IV&V Vendor shall evaluate the plans, requirements, environment, tools, and procedures used to test the system and ensure that it works according to specifications, is efficient, and satisfies all system and system interface requirements.

8) Data Management

The IV&V Vendor shall evaluate any needed plans, procedures and software for stat conversion and evaluate proposed database re-design activity to determine if it meets existing and proposed system requirements.

9) Operations Oversight

The IV&V Vendor shall evaluate change request and defect tracking processes, evaluate user satisfaction with the system to determine areas for improvement, evaluate the impact of the system on program goals and performance standards, evaluate operational plans and processes, and evaluate implementation of the process activities including backup, disaster recovery and day-to-day operations to verify that processes are being followed.

A.1.4.1 <u>Contractor Responsibilities for IV&V:</u>

The Contractor responsibilities listed below are the minimum required under this Contract. The Bureau and the Contractor may agree to assign additional responsibilities that may be incorporated into this Contract through an amendment.

A.1.4.1.1 Provide the IV&V Vendor access to the Contractor's project management plan, including recommendations for: adequate staff; staff skills, positions and abilities; equipment resources; training; and facilities;

A.1.4.1.2 Provide the IV&V Vendor access to project software development documents;

A.1.4.1.3 Facilitate IV&V Vendor review and monitoring of development processes to ensure they are being documented, carried out, and analyzed for improvement;

A.1.4.1.4 Facilitate IV&V Vendor review of project deliverables for accuracy, completeness, and adherence to contractual and functional requirements;

A.1.4.1.5 Facilitate IV&V Vendor review of the system documentation (e.g., Requirements, Training, Test Plans) for accuracy and completeness;

A.1.4.1.6 Facilitate IV&V Vendor analysis of applications, network, hardware and software operating platform performance characteristics relative to expected/anticipated/contractually guaranteed results and industry standards/expectations;

A.1.4.1.7 Facilitate IV&V Vendor assessment of software testing;

A.1.4.1.8 Facilitate IV&V Vendor assessment of user and system training;

A.1.4.1.9 Facilitate IV&V Vendor review of system hardware and software configuration; and

A.1.4.1.10 Facilitate IV&V Vendor review and assessment of any other TCMIS/Facilities Manager development or operational area identified in the IV&V plan approved by the Bureau.

A.1.4.2 Contractor Deliverables for IV&V:

A.1.4.2.1 Provide IV&V Vendor Project Work Plans, as delivered to the Bureau

A.1.4.2.2 Provide IV&V Vendor Unit Test Plans and schedule, as delivered to the Bureau

A.1.4.2.3 Provide IV&V Vendor Structured Test Plans and schedule, as delivered to the Bureau

A.1.4.2.4 Provide IV&V Vendor User Acceptance Test Plans and schedule, as delivered to the Bureau

A.1.4.2.5 Give IV&V Vendor test results daily, as tests are performed.

A.2 TCMIS Assessments and Enhancements

This Section outlines the Contractor's Assessments and Enhancement deliverables. Unless otherwise approved by the Bureau, failure to deliver these items as agreed to by the parties may result in the assessment of liquidated damages in accordance with Attachment B.

A.2.1 TCMIS Assessments

This Section describes the Assessments of the TCMIS. The Bureau of TennCare is seeking specific Assessments to the TCMIS with the constraint that the Assessments not jeopardize the operation under this Contract. Each Assessment shall be managed according to the project management guidelines described in Section A.1.

A.2.1.1 MAR Review

The Contractor shall review and assess the current Management and Administrative Reporting (MAR) processes and provide recommendations for improving Management and Administrative Reporting (MAR) as well as other TCMIS business analytics, decision support and dashboard capabilities for these key business processes.

The MAR system is a comprehensive management tool that provides information on program costs, provider participation and utilization trends and has the capability to analyze these historical trends and predict the impact of policy changes on programs. MAR reports are designed to assist management and administrative personnel with budget projections for the Bureau by providing statistical information on key TennCare program functions necessary to support the decision-making process. MAR reports are designed to supply detailed data on Bureau of TennCare business processes and summary information for the Bureau of TennCare's

business areas of Administrative, Operations, Provider Activity, Eligibility and Member Activity and Third Party Liability.

The TCMIS Management Reporting function provides information retrieval and reporting which supports policy planning, program evaluation and decision-making, fiscal planning and control, federal reporting, and operational planning and control. Information shall be retrieved from various TCMIS files/database tables for analysis and summarization.

During this four week assessment, the Contractor shall conduct interviews with key business and IT stakeholders, develop an understanding of business needs for reporting, dashboard and analysis capability.

The Contractor shall provide the following MAR Deliverables:

A.2.1.1.1.1 Project plan, schedule and staff engaged.

A.2.1.1.1.2 Cost/benefit analysis that includes the cost estimate for implementation of recommendations.

A.2.1.1.1.3 Recommendation paper for TennCare business intelligence governance, ownership and accountability, which is due no later than September 15, 2009. Recommendations shall be based on best practices and in accordance with State laws, rules and regulations and the best interests of the State, with the goal of attaining operational efficiencies while maintaining necessary process control and key business knowledge within the Bureau.

A.2.1.1.1.4 Recommendation paper for a TennCare roadmap from the current architecture and business processes to a more mature data warehouse and business intelligence oriented environment, which is due no later than September 15, 2009.

A.2.1.1.1.5 Informal presentation to Bureau staff, which shall describe the Contractor's recommendation, the procedures used by the Contractor to gather the information needed to make the recommendation and a cost/benefit discussion.

A.2.1.2 ICD-10 Design

The Contractor shall review the proposed changes to ICD coding in version 10, Procedural Coding System (PCS) and identify the changes needed in the TCMIS to accommodate them. The Contractor shall assess the extent of system changes and determine the associated updates needed to accommodate the new coding logic, including the performance of a detailed analysis of policy and system changes that will need to occur. The Contractor shall prioritize which subsystems will be changed and develop timelines and work plans for the changes. Consideration shall be given to:

Field-size expansion

Change to alphanumeric composition

Complete redefinition of code values and their interpretations

Edit and audit logic changes

Modifications of table structures

System interfaces

Benefit plan modifications

Program Cost Account logic

Ancillary systems, such as Medicaid Administrative Reporting (MAR) and Surveillance and Utilization Review (SUR)

Any necessary increases in system storage capacity to support both old and new coding systems for an appropriate period of time

Any necessary hardware upgrades to ensure optimal system performance

Dual-support time frame for ICD-9-CM, ICD-10-CM, and ICD-10-PCS coding

Analysis of the feasibility of a conversion plan to cross-reference between pre- and post-crossover periods in order to correlate the ICD-9-CM and ICD-10/CM/PCS data

Report formats and layouts need to be analyzed for possible modifications

The Contractor shall determine provider, billing vendor and software vendor readiness and vendor plans for upgrading software to new coding systems. This shall include communication with vendors of software that incorporates ICD codes to determine when upgrades reflecting the new coding systems shall be ready. This shall also include an assessment of the status of other business associates, such as Managed Care Organizations (MCOs), and their progress toward ICD-10 implementation.

The World Health Organization implemented a tenth revision of the International Classification of Diseases, Clinical Modification (ICD,CM) in much of the world in 1995. The National Committee for Health and Vital Statistics (NCHVS) has prepared a version for use in the United States which CMS proposes to mandate in 2011. NCHVS has developed ICD-10-CM, PCS (Procedural Coding System) for coding inpatient hospital procedures as ICD-10-CM did not allow such coding. This new revision shall dramatically expand the number of codes (from 15,000 to 120,000) and the digits in each code (3-5 to 5-7). There is additional potential for change in current MMIS processes as the DRG (Diagnosis Related Group) process shall also be impacted.

This assessment shall be for Phase 1, which includes the preparation of **design** documentation to modify the TCMIS to accommodate the ICD-10 coding. Included in Phase 1 shall be the creation of the plan for construction, configuration, testing and deployment work associated with the logic changes identified will be documented. The proposed implementation plan shall then be submitted as a separate Advanced Planning Document requesting approval for Phase 2 ICD-10 Remediation.

The Contractor shall provide the following ICD-10 Design Deliverables:

A.2.1.2.1 Project plan and schedule.

A.2.1.2.2 Requirements Validation Document.

A.2.1.2.3 Detailed Systems Design Document.

A.2.1.2.4 Letter requesting TennCare approval of Design.

A.2.1.2.5 Recommended implementation plan for the ICD-10 Remediation (Phase 2)

construction, configuration and testing.

A.2.1.2.6 Informal presentation to Bureau staff, which should describe the Contractor's Design recommendation.

A.2.2 Enhancements: Design, Development, Implementation, and Operation

This Section describes the System Enhancements of the TCMIS and Facilities Manager services. The Bureau of TennCare is seeking specific enhancements to the TCMIS with the constraint that the enhancements not jeopardize the TCMIS operation under this Contract. Each enhancement shall be managed according to the project management guidelines described in Section A.1. Additionally, each enhancement shall be developed and implemented through a standard System Development Life Cycle (SDLC) that shall include requirements analysis with appropriate Bureau staff, followed by design, development, testing, user acceptance testing, implementation, and validation of initial operations of the enhancement. This section provides the Contractor with information necessary to understand the extent of the required enhancements. The Bureau shall select the final enhancements to be made to the TCMIS based on budget and schedule considerations.

A.2.2.1 Professional Staffing Requirements for Enhancements

For each of the TCMIS Enhancements, the Contractor shall effect the enhancements with resources other than those dedicated to the TCMIS, except to the extent necessary to coordinate the implementation. The Contractor's ongoing operations Account Manager and the Bureau's TCMIS Systems Manager shall have administrative responsibility over the Enhancements to assure their proper coordination and compatibility with the existing TCMIS and ongoing operations.

The Bureau shall approve the Enhancement Project Manager and any other Key Personnel working on the enhancements. Where appropriate, the same person may be able to fill a position in different Contract phases.

The Enhancement Project Manager's general responsibilities shall be:

This person shall be the primary point of contact with the Bureau's TCMIS Project Director for activities related to the enhancement execution, including enhancement definition, design, and implementation activities according to the ITM, SDLC methodology and approach, TCMIS design changes, and acceptance testing activities. The Enhancement Project Manager shall coordinate and lead enhancement activities as conducted by the enhancement team and system staff. This position shall also be responsible for validating enhancement requirements and managing the completion of the design changes and deliverables through coding and testing. This position shall be further responsible for Contractor activities during acceptance testing of the enhancements. The Enhancement Project Manager shall be employed full-time at the Contractor's Tennessee location.

A.2.2.2 Location of Enhancement Functions

The staffing plan for each Enhancement shall identify the location of any off-site Enhancement support resources. The Contractor's regular project and progress reporting for Enhancements shall include status updates on the staffing level and location. The Contractor shall be responsible for providing desktops or laptops and secure connectivity to its off-site staff. If project

performance risk materializes, the parties shall jointly assess root causes and take actions as necessary to mitigate risk, potentially including but not limited to modifying the location where the support is performed. All Enhancement activities shall be performed in compliance with the prohibition of offshore disclosure and other provisions of Attachment C - HIPAA Business Associate Agreement.

The parties do not anticipate any need for Bureau travel to any location where off-site Enhancement activity is being performed. However, if such travel is subsequently determined to be beneficial to the Bureau for Enhancement project review or testing, the Contractor shall provide temporary space, hardware (e.g., workstation) and office equipment at that facility during the off-site visit.

A.2.2.3 Enhancement Process

The tasks associated with the development and implementation of each system enhancement shall be listed in the Facilities Management Enhancement Responsibilities (see Section A.2.5) and may differ in the level of effort required to complete each enhancement. The Bureau has a process in place for System Change Requests (SCRs) and major system enhancements that include the following steps which shall involve a collaborative effort by the Bureau and the Contractor:

1. Statement relating to scope of work or enhancement desired
2. Requirements gathering with representatives from Bureau policy and technical staff
3. Estimate of the amount of hours involved in the change
4. Proposed design of the change
5. Proposed schedule for the change
6. System and Acceptance Test plans
7. Conversion plan, if needed
8. Documentation updates
9. System Test plan updates
10. Conversion results, if needed
11. User acceptance testing
12. Implementation preparation, including any training
13. Final approval and sign-off
14. Post-implementation review and confirmation

Depending on the specific enhancement, the level of activity within any one (1) step may vary. Each step may not be applicable to each enhancement. The Bureau and the Contractor shall determine the responsibilities and deliverables associated with each step.

If work products for multiple enhancements are submitted to the Bureau and combined as a single deliverable, the Contractor shall clearly identify which ones are included in the submission and a reference to the Work Plan task shall be made. Except for changes related to an enhancement, the TCMIS shall continue to operate as it currently operates today. This includes

the appearance and navigation of the TCMIS windows, system processes, transaction processes, and any other system functions. It is understood that enhancements shall change certain functions or subsystems, but the TCMIS shall generally continue to operate as it did prior to the enhancement performed.

Once the enhancements are completed and approved by the Bureau, a review of the operational enhancements may be requested by the federal Centers for Medicare and Medicaid Services (CMS). The Contractor shall be expected to provide support and documentation to the review at no additional cost. The Bureau anticipates that such a review may entail one (1) to three (3) days of onsite time by CMS regional staff, depending on the scope of the requested review.

A.2.2.4 Enhancement Implementation Timeline

Enhancements may begin immediately after the Contract start date, but no later than three (3) months after the Contract start date. The Contractor shall be required to derive, and submit for approval by the Bureau, a schedule, Staff Plan and Work Plan for each enhancement, including all activities leading to the successful completion of deliverables and milestones for each enhancement, and for compliance with Bureau designated implementation dates.

Following are the requested Enhancements and the timeline for each based on the July 1, 2009 Contract start date:

Enhancement #1 – Capability Maturity Model Integration (CMMI) – This Enhancement requires the Contractor to lead the effort in raising the TennCare capability maturity level to Level Two within twenty-four (24) months of the Contract start date and to Level Three within twenty-four (24) months of being appraised at Level Two. The Contractor shall assess the current level, then plan, schedule, and implement the improvements necessary to reach CMMI Level Two. Appraisal of CMMI level shall be arranged by the Contractor and carried out by an independent third party. Once apprised of having reached CMMI Level Two, the Contractor shall begin the process of reaching CMMI Level Three.

Enhancement #2 – Technology Modernization – This Enhancement requires the Facilities Manager to support the Bureau's upgrade of specific hardware and software suites approaching end of life. The Contractor shall complete all technology modernization initiatives by June 30, 2010.

Enhancement #3 – Project Management Office (PMO) – This Enhancement requires the Contractor to create a PMO for coordinating the multiple aspects and projects within the TCMIS, and to follow the Project Management Body of Knowledge (PMBOK) guidelines for all changes, modifications, projects and enhancements. The creation of a PMO shall begin within two (2) months of the Contract start date, and shall be completed and fully operational by December 31, 2009.

Enhancement #4 – Commercial Off The Shelf (COTS) Dashboard – This Enhancement is to establish the use of a COTS dashboard software product (such as Crystal Xcelsius), that shall be used to report performance metrics and operations indicators. The Contractor shall complete testing, obtain Bureau approval, and implement this Dashboard software by June 30, 2010.

Enhancement #5 – COTS Documentation Software – The Contractor shall secure and operate COTS documentation software with enhanced content management features and enhance Filenet, to be an enterprise-wide content management

solution. This Enhancement to facilitate Systems Documentation shall be fully tested, Bureau approved, and implemented by June 30, 2010.

Enhancement #6 – Enhanced Testing Environment – The Contractor shall develop multiple integrated test environments with subsequent promotion to a full system test environment and finally promoted to a regression test environment prior to a production release. This shall require four (4) new test environments. The Contractor shall convert model office to the full systems test environment and the User Acceptance Test environment shall be converted to the regression test environment. This shall be implemented and fully operational by April 28, 2010.

Enhancement #7 – Business Process Improvement – This Enhancement requires the Contractor to develop a complete and detailed business process model of the Bureau and Contractor business processes, and that this process modeling shall include Activity Based Costing. The Contractor shall complete all process documentation by May 2, 2011.

Enhancement #8 – Long-Term Care CHOICES - This Enhancement requires the Contractor to support the Bureau's implementation of the Long-Term Care (LTC) CHOICES project. The Contractor shall complete all project documentation by March 11, 2011.

A.2.2.5 Facilities Manager General Enhancement Responsibilities

The Contractor shall derive and submit for approval by the Bureau, an Enhancement Work Plan and Schedule which includes at a minimum, the tasks listed below and the requirements with the Enhancements that the Bureau selects for implementation. The Contractor's Enhancement Work Plan shall be consistent with the proposed TCMIS project schedule and Deliverable Timetable. Specifically, the Contractor shall be required to implement the system Enhancements that the Bureau selects as described in Sections A.2.3 thru 10. The time frame for completion of the enhancements may demonstrate a phased approach to implementing the enhancements.

A.2.2.5.1 Contractor Requirements:

A.2.2.5.1.1 Meet with Bureau staff to discuss any details or issues related to the definition of enhancements, schedule for development, and implementation approach.

A.2.2.5.1.2 Obtain Bureau approval for each Enhancement Phase Work Plan.

A.2.2.5.1.3 Conduct a requirements analysis process for each enhancement.

A.2.2.5.1.4 Identify all necessary interface requirements with outside parties and systems.

A.2.2.5.1.5 Document the requirements for review and approval by the Bureau.

A.2.2.5.1.6 Develop detail system design or program specifications, with Bureau approval.

A.2.2.5.1.7 Develop a Test Management Plan and a test plan for each level of testing (e.g., Unit Test Plan, Integration Test Plan, System Test Plan). Each test plan shall specify the approach to testing, the items and features to be tested, the item pass/fail criteria, criteria for suspending and resuming tests, test environmental needs, test deliverables, testing tasks, responsibilities, staffing needs, training needs, test schedule, testing risks and contingencies, and testing approvals.

A.2.2.5.1.8 Develop and implement test plan progress measurement metrics for the purpose of monitoring system test and integration/regression test status.

A.2.2.5.1.9 Update and maintain the metrics on a weekly basis.

A.2.2.5.1.10 Submit testing status reports to the Bureau throughout the test period or as otherwise specified by the Bureau. Metrics shall include, but are not limited to:

a) the cumulative status of test scenarios;

b) those identified with problems and requiring retesting;

c) those that do not require a retest; and

d) the total population of test scenarios remaining throughout the test period.

A.2.2.5.1.11 Obtain Bureau approval of each Test Plan and the State Test Plan standards. Include a section in each test plan to define and document approvals.

A.2.2.5.1.12 Code modifications for the enhancements according to the approved specifications and the system design plan.

A.2.2.5.1.13 Prepare updated systems and operational documentation.

A.2.2.5.1.14 All systems and operational documentation shall be verified and approved by Contractor documentation management and quality assurance staff prior to submission to the Bureau.

A.2.2.5.1.15 Perform system tests and an integrated test of all system enhancements, improvements, and existing TCMIS processing, including system and regression testing.

A.2.2.5.1.16 Utilize the separate test environments created in Enhancement #6 to support the Bureau's user acceptance test effort.

A.2.2.5.1.17 Provide training to the acceptance testing team on preparing input data, using TCMIS screens, understanding TCMIS processes, and reviewing TCMIS outputs.

A.2.2.5.1.18 Assist the Bureau in implementation of the acceptance test with respect to generation of test transactions, data, and files as well as analysis of reasons for unanticipated processing results.

A.2.2.5.1.19 Provide operations staff to support acceptance test activities.

A.2.2.5.1.20 Finalize the implementation schedule based on Bureau approval.

A.2.2.5.1.21 Obtain Bureau approval for the updated systems and operational documentation.

A.2.2.5.1.22 Obtain Bureau approval for the implementation of each enhancement and system improvement.

A.2.2.5.1.23 Monitor the initial operation of each enhancement and system improvement to ensure that there are no immediate or ongoing adverse effects on the TCMIS as a result of the enhancement.

A.2.2.5.1.24 Whenever joint requirements validation sessions are needed, provide a facilitator to conduct these sessions.

A.2.2.5.2 Contractor Deliverables:

A.2.2.5.2.1 Prepare and submit to the Bureau an Enhancement Work Plan, Staff Plan and Schedule for each Enhancement, including any updates.

A.2.2.5.2.2 Conduct sessions for each Enhancement to ensure the requirements definition and analysis supports the Bureau's business processes.

A.2.2.5.2.3 Report to Bureau any business process re-engineering needed by either the Bureau or the Contractor for each Enhancement.

A.2.2.5.2.4 Submit a Requirements Analysis Document for each Enhancement

A.2.2.5.2.5 Submit a Design document for each Enhancement

A.2.2.5.2.6 Each test plan for each test level shall list all test deliverables from that testing level, their frequency and their distribution. Test deliverables shall include measures, metrics, and reports of both status and progress. Test deliverables for the System Test Plan shall include, but not be limited to, a report of:

a) the tests executed during a given week,

b) the number that are the initial tests,

c) the number that are re-tests,

d) the number of tests planned (initial and re-test),

e) the number of planned tests executed,

f) the number of planned tests not executed,

g) the percentage of planned tests executed,

h) the number of initial tests that passed,

i) the number of initial tests that failed (and those needing to be re-tested),

j) the number of re-tests that passed, and

k) the number of re-tests that failed (and those needing to be retested).

A.2.2.5.2.7 Testing reports shall be supplied weekly for as long as testing is in progress, for a given week and cumulatively to-date.

A.2.2.5.2.8 Create System Test Plan for each Enhancement, including testing responsibilities.

A.2.2.5.2.9 Create revised System and User Documentation incorporating each Enhancement.

A.2.2.5.2.10 Perform system testing for each Enhancement.

A.2.2.5.2.11 Create Integrated System Test Plan for each Enhancement.

A.2.2.5.2.12 Perform integrated system testing incorporating each Enhancement.

A.2.2.5.2.13 Distribute integrated system test results for each Enhancement.

A.2.2.5.2.14 Report Integrated System Test Progress Measurement Metrics incorporating each Enhancement.

A.2.2.5.2.15 Submit a Conversion Plan for each Enhancement, if required.

A.2.2.5.2.16 Submit Conversion Results for each Enhancement, if required.

A.2.2.5.2.17 Create and maintain a Problem Log Tracking Plan for each Enhancement.

A.2.2.5.3 Bureau Responsibilities:

A.2.2.5.3.1 Determine priority for Contractor's Enhancement activities.

A.2.2.5.3.2 Be available to the Contractor for consultation in the development of a detailed requirements analysis on changes.

A.2.2.5.3.3 Review and approve the detailed design for changes.

A.2.2.5.3.4 Monitor system modification activities in conjunction with other ongoing TCMIS changes.

A.2.2.5.3.5 Perform Bureau decision-making and review activities for the Enhancements.

A.2.2.5.3.6 Review and approve Enhancement Work Plans and Schedules.

A.2.2.5.3.7 Assist in creating test scenarios.

A.2.2.5.3.8 The Bureau shall be involved in all testing tasks and will use the Test Deliverables to evaluate testing progress.

A.2.2.5.3.9 Attend and participate in requirements validation sessions for Enhancement requirements.

A.2.2.5.3.10 Review Requirements Analysis and System Design Documents.

A.2.2.5.3.11 Review System Test Plans for each Enhancement, including testing responsibilities.

A.2.2.5.3.12 Review System and User Documentation.

A.2.2.5.3.13 Review Enhancement system testing.

A.2.2.5.3.14 Review integrated system testing incorporating Enhancement.

A.2.2.5.3.15 Assist in the development of test cases.

A.2.2.5.3.16 Review and approve updates to system documentation, only after the Contractor's documentation management and quality assurance staff have reviewed and approved it.

A.2.2.5.3.17 Review and approve updates to user documentation, operations procedures and procedure manuals, only after the Contractor's documentation management and quality assurance staff have reviewed and approved it.

A.2.2.5.3.18 Approve implementation of an enhancement prior to its installation and implementation into the TCMIS.

A.2.3 Enhancement #1 – Quality Improvement – CMMI

A.2.3.1 <u>Summary</u>

As part of the TennCare Management Information System (TCMIS), enhancements to the TCMIS are being requested. The quality of a system is highly influenced by the quality of the processes used to acquire, develop and maintain it. The Bureau is requiring the Contractor to adopt Capability Maturity Model Integration (CMMI) for the Bureau account for all Contractor managed business processes. CMMI is a suite of products (models, appraisal methods, training courses) used for improving processes. Some of the benefits of CMMI are improved process adherence, improved cost, improved schedule, improved quality and improved customer satisfaction. The Bureau is particularly interested in improved customer service for Bureau and system needs from the Contractor. The Contractor shall get appraised at both CMMI for Development and CMMI for Services, once CMMI for Services is available.

A.2.3.2 System Functionality Contractor Requirements:

A.2.3.2.1 The Contractor shall utilize software, including source code and version control software, to achieve Standard CMMI Appraisal Method for Process Improvement (SCAMPI) Class A appraisal at Maturity Level 2 and 3 of CMMI for Development and CMMI for Services.

A.2.3.3 Business Process Functionality Contractor Requirements:

A.2.3.3.1 The Contractor shall create a quality improvement unit, whose main function is to help the Contractor adopt CMMI for the Bureau of TennCare account. Payment for the Contract will be dependent upon obtaining successful CMMI appraisals at Level 2 and Level 3.

A.2.3.3.2 The Contractor shall be SCAMPI Class A appraised at Maturity Level 2 of version 1.2, or the most current version, of the Capability Maturity Model Integration for Development for all Contractor managed business processes including, but not limited to, the TCMIS and Mailroom, by a Software Engineering Institute (SEI) - authorized SCAMPI Lead Appraiser within twenty-four (24) months of the Effective Date of the Contract, or as otherwise approved by the Bureau.

A.2.3.3.3 While maintaining Maturity Level 2, or the appraised level from the requirement in Section A.2.10.3.2, of CMMI for Development, the Contractor shall be SCAMPI Class A appraised for all Contractor managed business processes at Maturity Level 3 of version 1.2, or the most current version, of the Capability Maturity Model Integration for Development by an SEI-authorized SCAMPI Lead Appraiser within twenty-four (24) months of the appraisal at Maturity Level 2 of version 1.2, or the most current version, of the Capability Maturity Model Integration for Development.

A.2.3.3.4 The Contractor shall be SCAMPI Class A appraised at Maturity Level 2 of version 1.2, or the most current version, of the Capability Maturity Model Integration for Services for all Contractor-managed business processes including, but not limited to, the TCMIS and Mailroom, by an SEI-authorized SCAMPI Lead Appraiser within twenty-four (24) months of the implementation date of the Bureau account, or within twenty-four (24) months of the availability of CMMI for Services, whichever is sooner.

A.2.3.3.5 While maintaining Maturity Level 2, or the appraised level from the requirement in Section A.2.10.3.4, of CMMI for Services, the Contractor shall be SCAMPI Class A appraised for all Contractor managed business processes at Maturity Level 3 of version 1.2, or the most current version, of the Capability Maturity Model Integration for Services by an SEI-authorized SCAMPI Lead Appraiser within twenty-four (24) months of the appraisal at Maturity Level 2 of version 1.2, or the most current version, of the Capability Maturity Model Integration for Services.

A.2.3.3.6 The Contractor shall ensure the continuity of on-going business processes before, during and after attaining CMMI levels 2 and 3 for Development and Services.

A.2.3.4 Contractor Deliverables:

A.2.3.4.1 Creation of Quality Improvement unit.

A.2.3.4.2 Appraisal at Maturity Level 2 of version 1.2, or the most current version, of CMMI for Development and CMMI for Services.

A.2.3.4.3 Appraisal at Maturity Level 3 of version 1.2, or the most current version, of CMMI for Development and CMMI for Services.

A.2.3.4.4 Training Plan.

A.2.3.4.5 Project Management Plan.

A.2.3.4.6 Communications Plan.

A.2.3.4.7 Process Gap Analysis.

A.2.3.4.8 Process Improvement Plan.

A.2.3.4.9 Status Reports.

A.2.4 Enhancement #2 – Technology Modernization

A.2.4.1 Summary

The Contractor shall staff initiatives to support the Bureau's upgrade of specific hardware and software suites approaching end of life.

A.2.4.2 System Functionality Contractor Requirements

A.2.4.2.1 Implement the Bureau's software infrastructure upgrades and port all applicable existing Bureau applications to Oracle 10g, Solaris 10, and PowerBuilder 11.5 to be completed by (date). The version to be upgraded may be updated by mutual agreement.

A.2.4.2.2 Conduct TCMIS performance tuning processes for the upgraded infrastructure

environment.

A.2.4.2.3 Implement data warehouse enhancements, including transition of MAR to a data warehouse structure, implementation of SUR Enhanced Profiler and implementation of the upgrade to Business Objects XI.

A.2.4.2.4 Complete a one-time TCMIS Security Risk Assessment.

A.2.4.2.5 Develop a migration plan from Oracle Financial to interChange Financial to simplify the technical architecture and improve cost efficiency.

A.2.4.2.6 Implement enhancements to the Bureau's version and source code control software and processes.

A.2.4.3 Business Process Functionality Contractor Requirements

A.2.4.3.1 The Contractor shall provide the overall project approach and schedule for the initiatives included in this enhancement.

A.2.4.3.2 The Contractor shall provide staff that are experienced and proficient to perform the software upgrades, performance tuning, migration plan development and security risk assessment.

A.2.4.3.3 The Contractor shall coordinate with State of Tennessee, Office of Information Resources staff, a key stakeholder in these initiatives, as necessary for modernization and risk assessment.

A.2.4.3.3.1 The Contractor shall ensure the continuity of on-going business processes before, during and after implementation of this enhancement.

A.2.4.3.4 The Contractor shall perform a TCMIS Risk Assessment in accordance with the guidance of NIST Special Publication (SP) 800-53A, Guide for Assessing the Security Controls of Federal Information Systems, and the evaluation criteria set forth in NIST SP 800-30. The Risk Assessment is targeted to be a total effort of up to four hundred and fifty (450) work hours. The primary focus of the risk assessment is to identify vulnerabilities in the Bureau's information system that could potentially be exploited by a threat agent and to determine the level of risk posed by the threat/vulnerability pairing given the current state of existing security controls.

A.2.4.3.5 The Contractor shall determine a migration path for Oracle Financial data to interChange Financial.

A.2.4.3.6 The Contractor shall implement enhancements to the Bureau's version and source code control software and processes.

A.2.4.3.7 The Contractor shall determine the migration path for porting all applicable applications to Oracle 10g, Solaris 10 and PowerBuilder 11.5.

A.2.4.3.8 The Contractor shall submit any material changes to system architecture for state review and approval.

A.2.4.4 Contractor Deliverables

A.2.4.4.1 Provide overall project approach, schedule and staffing plan.

A.2.4.4.2 Obtain Bureau acceptance and approval of testing and validation recommendations for infrastructure software upgrades and data warehouse transitions.

A.2.4.4.3 Implement infrastructure software upgrades to Oracle 10g, Solaris 10 and PowerBuilder 11.5.

A.2.4.4.4 Conduct TCMIS performance tuning processes for the upgraded infrastructure environment.

A.2.4.4.5 Implement data warehouse enhancements, including transition of MAR to a data warehouse structure, implementation of SUR Enhanced Profiler and implementation of the upgrade to Business Objects XI.

A.2.4.4.6 Submit a report to the Bureau outlining the recommended migration plan from Oracle Financial to interChange Financial

A.2.4.4.7 Submit a TCMIS Risk Assessment report to the Bureau outlining recommendations for mitigation techniques and strategies to support client policy or standards requirements, and security industry best practices.

A.2.4.4.8 Obtain Bureau acceptance and approval of the testing and validation results for the infrastructure software upgrades and porting of all applicable application to Oracle 10g, Solaris 10 and PowerBuilder 11.5 prior to the cutover to production.

A.2.4.4.9 Obtain Bureau acceptance and approval of the testing and validation results for the data warehouse initiatives prior to the cutover to production; Conduct an informal presentation for the Bureau at the completion of each initiative in this enhancement to summarize the results.

A.2.5 Enhancement #3 - Project Management Office

A.2.5.1 Summary

The Bureau is requiring the creation of a Project Management Office (PMO) by the Contractor for the TennCare Management Information System (TCMIS). The main function of the PMO shall be to assist in the coordination of the multiple projects being managed by the Contractor and assist in the development of a project management tool set to be used by the Contractor staff. Projects are a means of organizing activities that cannot be addressed within the organization's normal operational limits. Projects are, therefore, often utilized as a means of achieving an organization's strategic plan. Project management is the application of knowledge, skills, tools and techniques to project activities to meet project requirements.

A.2.5.2 Contractor PMO Deliverables:

A.2.5.2.1 Establish Project Management Office:

A.2.5.2.1.1 The Contractor shall establish a Project Management Office which shall contain staff to develop and facilitate the necessary PMO methodologies, policies and procedures;

A.2.5.2.1.2 Institute policies, processes and procedures for management of PMO;

A.2.5.2.1.3 The Contractor shall maintain the PMO to oversee all TCMIS projects and ongoing system functionality;

A.2.5.2.1.4 The Contractor shall have procedures in place that make certain all requirements for Project Management are met; and

A.2.5.2.1.5 Project Managers shall be certified as a Project Management Professional (PMP) or have equivalent experience.

A.2.5.2.2 Develop and Implement Processes to Control Scope of Work:

A.2.5.2.2.1 The Contractor shall develop, and submit to the Bureau for approval, a proposed procedure for resolving any dispute between the Bureau and the TCMIS Contractor as to whether any requirement of the Bureau is within the scope of work covered by this Contract. In the event that the scope dispute procedure determines that work required by the Bureau is beyond the scope of work covered by this Contract, the change management process shall be used to describe, quantify, and approve any additional tasks.

A.2.5.2.3 Develop and Implement Other Processes to Oversee the Work Performed:

A.2.5.2.3.1 The Contractor shall apply the principles of Capability Maturity Model ® (CMM), or a comparable model, for all application development and maintenance. The Contractor shall develop in its response to this Contract a description of its application development and maintenance methodology, and identify the approach to:

a) Requirements Management;

b) Project Planning;

c) Subcontractor Management;

d) Software Configuration Management;

e) Process Focus;

f) Process Definition;

g) Quality Assurance;

h) Training;

i) Integrated Software Management;

j) Software Product Engineering; and

k) Peer Reviews.

A.2.5.2.3.2 The Contractor shall develop a formal internal Quality Assurance Program to address all aspects of its projects and monitor its day-to-day operations. This task shall include the development of checklists, measures and tools to measure the level of quality of each deliverable and ongoing business operations. The quality measurement process applies to plans and documents, as well as programs and operational functions.

A.2.5.2.4 Develop Earned Value Management System (EVMS) Metrics:

A.2.5.2.4.1 The Contractor shall develop Earned Value Management System (EVMS) Metrics to monitor processes and procedures and to report earned value performance measurement statistics to quantify variances from the project plan, including an auditable tracking system to collect the estimated resource costs and actual costs of accomplishing the project work activities in sufficient detail to support the monthly reporting of the earned value factors of the budgeted cost of work scheduled (BCWS), the actual cost of work performed (ACWP), and the budgeted cost of work performed (BCWP). The rigor of a given project's EVMS shall be governed by several factors: the more significant factors are size, duration, and nature of the work. Whatever the rigor required, the system shall be documented with descriptions of the processes, the tools, and the roles that comprise the EVMS. The method and formulas for calculation of EVMS shall be reviewed and approved by the Bureau prior to use on the project.

A.2.5.2.5 Develop an Operations Management Plan:

A.2.5.2.5.1 The Contractor shall develop a comprehensive Operations Management Plan for review and approval by the Bureau. The plan shall address how the Contractor will manage day-to-day Facilities Manager Operations.

A.2.5.2.6 Implementation of Project Management Office Operations

A.2.5.2.7 Project Charter Documentation, Refer to Section A.2.5.4.4

A.2.5.2.8 Stakeholder Analysis Documentation – Refer to Section A.2.5.4.5

A.2.5.2.9 Project Status Reporting Documentation – Refer to Section A.2.5.4.15

A.2.5.2.10 Requirements Analysis Documentation – Refer to Section A.2.5.4.16

A.2.5.2.11 Business Design Documentation – Refer to Section A.2.5.4.17

A.2.5.2.12 Technical Design Documentation – Refer to Section A.2.5.4.18

A.2.5.3 <u>System Functionality Contractor Requirements:</u>

A.2.5.3.1 The Contractor shall utilize Project Management software, such as Microsoft Project, as directed by the Bureau.

A.2.5.3.2 The Contractor shall consolidate reports required for the management of projects by either integrated project management tools or COTS products.

A.2.5.3.3 The Contractor shall develop or use a COTS correspondence management system to manage official correspondence between the Contractor and the Bureau. The system shall be web-based and conform to MMIS architecture or State standards.

A.2.5.4 Business Process Functionality Contractor Requirements:

A.2.5.4.1 The Contractor shall create a Project Management Office (PMO) and shall follow the Project Management Body of Knowledge (PMBOK) guidelines for managing a project.

A.2.5.4.2 The Contractor shall coordinate Project Management activities with the Bureau's Project Management Office.

A.2.5.4.3 The Contractor PMO shall follow the project management steps as appropriate to the size of the project, as well as on-going projects and operations:

Project - Any work task with a defined beginning and end, a defined result, and requiring more than one (1) full time equivalent (FTE) work month of estimated effort;

Small Project - Any work task with two (2) to six (6) FTE work months of estimated effort;

Medium Project - Any work task with seven (7) to twelve (12) FTE work months of estimated effort; and

Large Project - Any work task with more than twelve (12) FTE work months of estimated effort.

A.2.5.4.4 Project Charter - The Contractor shall provide a Project Charter for all projects. The project charter shall include: Title of the Project, Name of the Project Manager, Result/Product of the Project, Authority of the Project Manager, Constraints, Assumptions, Executing Authority (approval of management), and Date approved.

A.2.5.4.5 Stakeholder Analysis - The Contractor shall provide a Stakeholder Analysis for all Medium and Large Projects, including: identification of an Executive Sponsor for each project at the Bureau and Contractor level, identification of stakeholders and their roles/interests/expectations, stakeholder contact information and establishment of lines of authority and reporting responsibilities for the project.

A.2.5.4.6 Communications Management Plan - The Contractor shall provide a Communications Management Plan for all Projects. Early in the Project, the Contractor shall determine all Bureau communications needs, including status reporting and project monitoring, and create a process to meet those needs.

During the project, the Contractor shall execute the plan with agreed upon interval (e.g., weekly) status reports in formats approved by the Bureau. At the end of the project, the Contractor shall meet with the Bureau to receive quality improvement feedback, and shall record lessons learned for use in future Projects.

A.2.5.4.7 Work Breakdown Structure - Early in every Project, the Contractor shall perform scope planning and scope definition tasks to result in a Work Breakdown Structure (WBS), known informally as the Project Plan. This WBS shall identify and record all major tasks, milestones and deliverables associated with the Project. The work shall be decomposed into tasks that allow for accurate estimation of the work and resources required to complete the project. Any task that requires more than eighty (80) hours or ten (10) workdays to complete shall be further decomposed. During execution of the project, the Contractor shall measure performance according to the WBS and manage changes to the plan requested by the Bureau. When tasks are complete, the Contractor shall seek verbal acceptance from the Bureau for each task, and formal acceptance of each deliverable.

A.2.5.4.8 Risk Management Plan - The Contractor shall develop and use a standard Risk Management Plan approved by the Bureau for all Medium and Large Projects. The plan shall address the process and timing for risk identification, describe the process for tracking and monitoring risks, identify the Contractor staff that shall be involved in the risk management process, identify the tools and techniques that shall be used in risk identification and analysis, describe how risks shall be quantified and qualified, and how the Contractor shall perform risk response planning. The Contractor shall produce lists of identified risks and, for each risk, the Contractor shall evaluate and set the risk priority based on likelihood the risk shall occur and impact, assign risk management responsibility, and create a risk management strategy. For each significant accepted risk, the Contractor shall develop risk mitigation strategies to limit the impact. The Plan shall include aggressive monitoring for risks, identify the frequency of risk reports, and describe the plan for timely notification to the Bureau of any changes in risk or trigger of risk events.

A.2.5.4.9 Cost Management Plan - Early in every project, the Contractor shall determine the resources necessary to complete the project in a timely and efficient manner, and shall estimate and budget for costs, and post these estimates to each task in the WBS. Although in most cases the costs shall not be chargeable to the Bureau, the estimate shall be used by the Bureau for planning and setting priorities, and shall be used by the Bureau and the Contractor to report cost variance. During execution of the project, the Contractor shall regularly report cost variance at the task level, based on the percentage completion of the task and the actual number of hours or days worked on the task.

A.2.5.4.10 Quality Management Plan - The Contractor shall employ a formal Quality Management Plan for each Large Project. Early in the Project, the Contractor shall develop checklists, measures and tools to measure the level of quality of each deliverable. The quality measurement process applies to plans and

documents, as well as programs and operational functions. The Quality Management plan shall reflect a process for sampling and audits and for continuous quality improvement.

A.2.5.4.11 Staffing Management Plan - For all projects, the Contractor shall create a Staffing Management Plan, including organizational charts with defined responsibilities and contact information. Resources shall be allocated by name or by type to the WBS, and hourly rates shall be listed for all assigned staff. Staff allotted to a project shall remain on that project for the duration of the project. During project execution, the Contractor shall provide appropriate training and management supervision to all staff.

A.2.5.4.12 Time Management and Project Schedule - For all projects, the Contractor shall create a Project Schedule. The Project Schedule shall include duration estimates for each task in the WBS, the sequence of tasks, including identification of the critical path, and the method to be used by the Contractor to control time spent on the project.

A.2.5.4.13 Project Execution and Control - During execution of every project, the Contractor shall exert control to assure the completion of all tasks according to the Project Schedule and Project Budget. All variances shall be reported to the Bureau, and the Contractor shall coordinate with the Bureau to address any variance in a manner to ensure overall completion of the Project within time and budget constraints. The Bureau shall coordinate with the Contractor to approve fast-tracking or reallocation of Contractor resources as necessary.

A.2.5.4.14 Integration Management - All requirements for project management are interrelated. The Contractor may apply integrated project management tools or COTS products to consolidate reports required for the management of projects. The Contractor shall execute careful change control on every project. The Contractor shall develop or use a COTS correspondence management system to manage official correspondence between the Contractor and the Bureau. The system shall be web-based and conform to MMIS architecture or State standards. All written and official electronic correspondence between the Contract Manager and the Contractor shall be logged, archived and maintained by the Contractor. In the event of contract turnover, the Contractor must provide the Bureau with all official correspondence in hard and soft copy in accordance with A.3.21.4.3 Turnover of Documentation.

A.2.5.4.15 Project Status Reporting - For all projects, the Contractor shall prepare written status reports in formats approved by the Bureau and attend status meetings on a schedule approved by the Bureau. Before each status meeting, the Contractor shall prepare:

A.2.5.4.15.1A general status report;

A.2.5.4.15.2Activities completed in the preceding period;

A.2.5.4.15.3Activities planned for the next period;

A.2.5.4.15.4A report on issues that need to be resolved;

A.2.5.4.15.5 A report on the status of risks, with special emphasis on change in risks, risk triggers, or the occurrence of risk items;

A.2.5.4.15.6 A report on the status of each task in the WBS that is in progress or overdue;

A.2.5.4.15.7 A cost variance report showing the planned value of the work completed to date, the actual cost of the work completed to date and the variance;

A.2.5.4.15.8 A schedule variance report showing the earned value of the work completed, the planned value of the work completed, and the variance;

A.2.5.4.15.9 Monthly and Quarterly Status reports shall summarize data from the agreed upon interval (e.g., weekly) reports, include financial information related to expenses and billings; and

A.2.5.4.15.10 Include executive summaries for presentation to management and oversight bodies.

A.2.5.4.16 Requirements Analysis Document - For all projects, the Contractor shall develop a Requirements Analysis Document, which shall include, but not be limited to, the following:

A.2.5.4.16.1 Executive Summary;

A.2.5.4.16.2 Overview of all processes;

A.2.5.4.16.3 Overview and purpose of all interfaces;

A.2.5.4.16.4 Discussion of the design implications for each major element of the project;

A.2.5.4.16.5 System designs or modifications necessary to complete the project;

A.2.5.4.16.6 General report definitions;

A.2.5.4.16.7 General screen definitions;

A.2.5.4.16.8 System behavior model (user interfaces-free form); and

A.2.5.4.16.9 High-level flowcharts.

A.2.5.4.17 Business Design Document - For all projects, the Contractor shall develop a Business Design Document, which shall include, but not be limited to, the following:

A.2.5.4.17.1 Purpose and general business description of each program, module, screen, process, and report;

A.2.5.4.17.2 Lists of inputs, outputs and interfaces;

A.2.5.4.17.3 Process flowcharts; and

A.2.5.4.17.4 General resource requirements.

A.2.5.4.18 Technical Design Document - For all projects, the Contractor shall develop a Technical Design Document, which will include, but not be limited to, the following:

A.2.5.4.18.1 Hardware and software requirements, including Data Model changes

A.2.5.4.18.2 Program, screen and report specifications sufficient to begin programming and construction;

A.2.5.4.18.3 Database design or change specifications

A.2.5.4.18.4 Pseudo-code may be introduced at the discretion of the project team for complex issue resolution

A.2.5.4.18.5 Data conversion and interface requirements.

A.2.5.4.19 The Contractor shall ensure the continuity of on-going business processes before, during and after creation of the PMO.

Table of Project Management Contractor Requirements for Section A.2.5.4

This table lists the deliverables and contents that shall be required, depending on the project size.

Deliverable	Contents	Small Project	Medium Project	Large Project
Project Charter	• Title of Project • Name of the Project Manager • Authority of the Project Manager • Result/Product of the Project • Constraints • Assumptions • Executing Authority • Date Approved	X	X	X
Stakeholder Analysis	• Identification of Bureau & Contractor Executive Sponsor for the Project • Identification of stakeholders • Stakeholder roles/interests/expectations • Stakeholder contact information • Establish lines of authority & reporting responsibilities	X	X	X
Communications Management Plan	• Method and frequency of meetings and status reports for each stakeholder • Feedback loops • Project contact list • Record lessons learned	X	X	X
Scope Planning and Definition - Work Breakdown Structure (WBS)	• Identify all tasks, deliverables and milestones • Start date, end date, and work effort for all tasks • Task dependencies	X	X	X

Deliverable	Contents	Small Project	Medium Project	Large Project
	• Resource allocation by task and role • Decompose so no task has estimated work effort more than eighty (80) hours			
Risk Management Plan	• Identification of risks • Process for tracking and monitoring risks • Identification of risk management Contractor staff • Tools and techniques used to identify risks • Describe how risks shall be quantified and qualified • Contractor plan for risk response planning • Schedule for assessment of risks • Assignment of risk management responsibility • Risk management strategy and risk mitigation strategy		X	X
Resource Management Plan	• Determine necessary resources • Estimate and budget resources • Post estimates to WBS tasks • Report resource variance at project level		X	X
Quality Management Plan	• Checklists, measures, and tools used to measure quality • Process for sampling and auditing for quality improvement			X
Staffing Management Plan	• Organizational charts • Defined responsibilities of staff • Key staff contact information • Resource allocation by name or type to WBS		X	X
Time Management - Project Schedule	• Task duration estimates • Task sequence • Critical path identification • Time control methods	X	X	X
Project Execution and Control	• Adherence to Project Schedule and Budget • Report of all variances • Corrective action plan • Project update plan	X	X	X

Deliverable	Contents	Small Project	Medium Project	Large Project
Integration Management	• Integrated project management tool or COTS product to consolidate reports • Correspondence management system (developed or COTS)	X	X	X
Project Status Reporting: Weekly, Monthly, and Quarterly	• General status report • Completed activities • Planned activities • Project issues • Risk status • WBS task status • Contractor cost variance report (CPI) • Schedule variance report (SPI) • Financial information • Executive summaries		X	X
Requirements Analysis Document	• Executive Summary • Overview of all processes • Overview and purpose of all interfaces • Discussion of the design implications for each major element of the project • System designs or modifications necessary to complete the project • General report definitions • General screen definitions • System behavior model (user interfaces-free form) • High-level flowcharts	X	X	X
Business Design Document	• Purpose and general business description of each program, module, screen, process, and report • Lists of inputs, outputs and interfaces • Process flowcharts • General resource requirements	X	X	X
Technical Design Document	• Hardware and software requirements • Program, screen and report specifications sufficient to begin programming and construction • Database design or change	X	X	X

Deliverable	Contents	Small Project	Medium Project	Large Project
	specifications • Data conversion (if needed), and interface requirements			
On-going Operations	• The Contractor shall ensure the continuity of on-going business processes before, during and after creation of the PMO.	X	X	X

A.2.5.5 Contractor Deliverables for Each Project:

Depending on the size of the project, some deliverables may not be applicable (refer to the table above). The deliverables may include, but are not limited to, the following:

A.2.5.5.1 PMO Processes, Policies and Procedures.

A.2.5.5.2 Project Charter.

A.2.5.5.3 Stakeholder Analysis.

A.2.5.5.4 Communications Management Plan.

A.2.5.5.5 Project Scope Statement.

A.2.5.5.6 Project Plan.

A.2.5.5.7 Risk Management Plan.

A.2.5.5.8 Procedure and data sources for calculation of EVMS.

A.2.5.5.9 Quality Management Plan.

A.2.5.5.10 Staffing Management Plan.

A.2.5.5.11 Detailed Work Plan and Project Schedule.

A.2.5.5.12 Project Management Reports & Correspondence.

A.2.5.5.13 Status Reports.

A.2.5.5.14 Requirements Analysis Document.

A.2.5.5.15 Business Design Document.

A.2.5.5.16 Technical Design Document.

A.2.5.5.17 Operations Management Plan.

A.2.5.5.18 Training Manual.

A.2.5.6 Bureau Responsibilities:

Bureau responsibilities include the following:

A.2.5.6.1 Approve Contractor's PMO methodologies.

A.2.5.6.2 Coordinate projects with Contractor PMO.

A.2.6 Enhancement #4 – COTS Dashboard

A.2.6.1 Summary

The Contractor shall create dashboard metrics that shall have the capability to be customized by the TennCare Management Information System (TCMIS) users. Currently, the Bureau does not have any dashboard reporting of key operational and production metrics. A COTS (Commercial Off-The-Shelf) software package such as Business Objects' Crystal Xcelsius scorecarding and dashboard software shall be used to perform dashboard reporting of key operational and production metrics. An interactive business dashboard may turn data into an intuitive visual presentation and may model the future performance of TennCare programs through "what-if" analyses.

A.2.6.2 System Functionality Contractor Requirements:

A.2.6.2.1 The Contractor shall create the Dashboards to do the following:

A.2.6.2.1.1 Combine financial information with operational information to provide a complete view of performance.

A.2.6.2.1.2 Utilize data resources to present users with clear summary information.

A.2.6.2.1.3 Achieve performance insight through the strongest visual navigation and analysis tool.

A.2.6.2.1.4 With input from the Bureau, create definitions of requirements to reduce design iterations and leverage proper metrics.

A.2.6.2.1.5 Update dynamically from live data and be available on the State intranet.

A.2.6.2.1.6 Track all performance indicators and penalties with the dashboard software.

A.2.6.2.1.7 The Contractor shall create the Dashboards to include online screens containing up-to-date summary information including, but not limited to, the total numbers and categories of:

Providers

Recipients

Services

A.2.6.2.2 The Contractor shall create the Dashboards to show claims throughput activity, claims backlog, key entry backlog, pend file status, and other performance items, as determined by the Bureau.

A.2.6.2.3 The Contractor shall incorporate the ability to report on and add indicators to the Dashboards, as determined by the Bureau.

A.2.6.2.4 The Contractor shall use Crystal Xcelsius or similar COTS software, to create the Dashboards.

A.2.6.2.5 The Contractor shall integrate the COTS Dashboard software with the TCMIS, including interChange Bureau SharePoint and Business Objects environment.

A.2.6.3 Business Process Functionality Contractor Requirements:

A.2.6.3.1 The Contractor shall provide, maintain and update Dashboards that apply appropriate analytics to source data and present the resulting information in a way that makes actionable events or trends immediately apparent to the user.

A.2.6.3.2 The Contractor shall maintain the dashboard software as a data source that is updated hourly, daily, weekly, or monthly, as defined by the Bureau.

A.2.6.3.3 The Contractor shall create Dashboards with key performance metrics, as specified in Section B.4. of Attachment B of this Contract defining the Dashboard Performance Metrics, which can be customized for each business user.

A.2.6.3.4 The Contractor shall make Dashboards available to all appropriate staff, as defined by the Bureau.

A.2.6.3.5 The Contractor shall be able to add Dashboard indicators, as requested by the Bureau.

A.2.6.3.6 The Contractor shall ensure the continuity of on-going business processes before, during and after implementation of the Dashboard software.

A.2.6.3.7 The Contractor shall develop a Detail System Design (DSD), User Manual, Operations Manual and Training Manual for the Dashboard software.

A.2.6.4 Contractor Deliverables:

A.2.6.4.1 Procurement of Crystal Xcelsius, or similar Dashboard COTS software, in accordance with Section C.3 Payment, Paragraph (f) Hardware, Software and Maintenance.

A.2.6.4.2 Implementation of COTS Dashboard software.

A.2.6.4.3 Customization for TennCare of COTS Dashboard software.

A.2.6.4.4 Integration with interChange of COTS Dashboard software.

A.2.6.4.5 COTS Dashboard Detail Design Document.

A.2.6.4.6 COTS Dashboard User Manual.

A.2.6.4.7 COTS Dashboard Operations Manual.

A.2.6.4.8 COTS Dashboard Training Manual.

A.2.6.4.9 Testing and Bureau acceptance of COTS Dashboard software.

A.2.6.4.10 Completion and Implementation of Enhancement # 4, installation of COTS Dashboard software.

A.2.7 Enhancement #5 – COTS Documentation Software

A.2.7.1 Summary

The Contractor shall secure Commercial Off-The-Shelf (COTS) documentation software with enhanced content management features and enhance Filenet to be utilized for Systems Documentation of the TennCare Management Information System (TCMIS) in accordance with Section C.3 Payment, Paragraph (f) Hardware, Software and Maintenance. Documentation is of critical importance to any business. Documentation software can help empower staff by connecting them with the right information quickly, so that they can transform business data into organizational knowledge and action. COTS documentation software packages are available to house systems infrastructure and operational documentation, which can then be used for collaboration among business users and be integrated with dashboard and scorecard software.

A.2.7.2 System Functionality Contractor Requirements:

A.2.7.2.1 The Contractor shall secure documentation software that shall retain prior versions of published documents, including Contractor work products and deliverables.

A.2.7.2.2 The Contractor shall secure documentation software that shall include content navigation capabilities (e.g., content topology, hierarchy).

A.2.7.2.3 The Contractor shall secure documentation software capable of containing content including, but not limited to:

A.2.7.2.3.1 Documentation User Manuals

A.2.7.2.3.2 COTS Documentation Quick Reference User Documents

A.2.7.2.3.3 Documentation Operations Manuals

A.2.7.2.3.4 Documentation Procedure Manuals

A.2.7.2.3.5 Documentation Training materials

A.2.7.2.3.6 Technical documentation including Configuration management

A.2.7.2.3.7 Documentation Software Interfaces

A.2.7.2.3.8 Documentation Deliverables

A.2.7.2.3.9 COTS Documentation Test plans

A.2.7.2.3.10 COTS Documentation Test results

A.2.7.2.3.11 Performance metrics

A.2.7.2.3.12 Documentation standards

A.2.7.2.3.13 Requirements for the various types of documentation repository for all documentation related to the TennCare program.

A.2.7.2.4 The Contractor shall secure documentation software that is searchable by subject matter.

A.2.7.2.5 The Contractor shall secure documentation software that has keyword and soundex search capability.

A.2.7.2.6 The Contractor shall secure documentation software that has web link integrity checking (to eliminate ”page not found” errors).

A.2.7.2.7 The Contractor shall secure documentation software that has the ability to provide internal and external access by security levels.

A.2.7.2.8 The Contractor shall secure documentation software that shall allow for migration of existing documentation contained in current repositories (e.g., Project Work Book (PWB)) to the new solution.

A.2.7.2.9 The Contractor shall secure documentation software that provides structured workflow (including review, revision and approvals) for production of all document deliverables and publication materials.

A.2.7.2.10 The Contractor shall secure documentation software that is capable of electronic notification (e.g., broadcast emails) when content is revised or initially published to interested parties.

A.2.7.2.11 The Contractor shall secure documentation software with twenty-four (24) hours per day, seven (7) days per week availability and operability (fully functional) except for agreed upon scheduled maintenance periods.

A.2.7.2.12 The Contractor shall secure documentation software that shall integrate document imaging and workflow with the TCMIS procured under this Contract.

A.2.7.2.13 The Contractor shall secure documentation software that provides a unique identifier for each entity, including version designation.

A.2.7.2.14 The Contractor shall secure documentation software that shall integrate functionality with the TeamTrack application.

A.2.7.2.15 The Contractor shall secure documentation software that is capable of fully

configurable access and security by individual, group, or requestor type.

A.2.7.2.16 The Contractor shall secure documentation software that will integrate with interChange.

A.2.7.3 Business Process Functionality Contractor Requirements:

A.2.7.3.1 The Contractor shall enhance the existing Document Imaging, Storage and Retrieval application, subject to approval from the Bureau, to include an enterprise-wide content management solution using the existing FileNet application.

A.2.7.3.2 The Contractor shall ensure the continuity of on-going business processes before, during and after implementation of the COTS documentation software.

A.2.7.3.3 The Contractor shall develop a Detail System Design (DSD) and User Manual for the COTS Documentation software. Documentation from the COTS product itself may be incorporated to provide this information.

A.2.7.3.4 The Contractor shall perform updates to correct existing documentation gaps identified by the Bureau.

A.2.7.4 Contractor Deliverables:

A.2.7.4.1 Procurement of Documentation software, in accordance with Section C.3 Payment, Paragraph (f).

A.2.7.4.2 Implementation of Documentation software.

A.2.7.4.3 Customization for TennCare of Documentation software.

A.2.7.4.4 Integration with interChange and TeamTrack of Documentation software.

A.2.7.4.5 Documentation User Manual.

A.2.7.4.6 Documentation Operations Manual.

A.2.7.4.7 Documentation Training Manual.

A.2.7.4.8 Testing and Bureau acceptance of COTS Documentation software.

A.2.7.4.9 Completion and Implementation of Enhancement # 5, installation of COTS Documentation software.

A.2.8 Enhancement #6 – Enhanced Testing Environment

A.2.8.1 Summary

Another enhancement is an enhanced testing environment to allow for multiple test environments. Due to numerous simultaneous priority system changes, the Bureau is constantly required to hold system changes because a priority change is being tested in UAT and testing other system changes will interfere. Therefore, the Bureau is requiring the Contractor to develop and manage testing components in multiple systems testing environments.

Testing processes shall involve user participation throughout, not just at the end of the testing process, which was originally referred to as UAT.

The enhanced TCMIS testing environments shall facilitate the various levels of testing according to State standards.

a) Unit testing – performed by the Contractor developers in the development environment for single unit tests

b) Model Office testing – performed by the Contractor testers and Business Services Analysts to confirm readiness for Integration testing

c) Integration testing – performed by the Contractor and Bureau in the new integrated test environments to test multiple parts of an integrated system

d) UAT Staging – Performed by the Contractor in the new full system test environment to confirm readiness for UAT

e) UAT and regression testing – Performed by the Contractor and Bureau to simulate production and for final acceptance that the change is correct

To facilitate emergency changes, or high priority change requests, without interruptions, one (1) integrated test environment shall be allocated for changes that shall be quickly implemented

A.2.8.2 <u>System Functionality Contractor Requirements:</u>

A.2.8.2.1 The Contractor shall operate and maintain enhanced testing environments.

A.2.8.2.2 The Contractor shall ensure that multiple priorities can be tested simultaneously.

A.2.8.2.3 Ensure that the testing environments include a complete online TCMIS test system, including a test version of all batch and online programs and files to be used for testing releases and non-release changes.

A.2.8.2.4 The enhanced test environment shall include the following:

A.2.8.2.4.1 Create and Implement four (4) Integrated Testing Environments:

1) Eligibility/Enrollment
2) Claims/Encounters
3) Special Projects
4) Other

The allocation of these testing environments shall be revised, as needed by the Bureau.

A.2.8.2.4.2 The UAT Staging environment will be used to merge code from the Integrated Test environments and confirm readiness for release to UAT and Regression.

A.2.8.2.4.3 A UAT and Regression testing environment shall be used to test the merged code from the integrated testing environments. Any change that fails testing in the full systems testing environment shall be corrected and retested in the integration testing environment. Any changes that pass testing in the full systems testing environment shall be promoted to the regression testing environment.

A.2.8.2.4.4 Complete regression testing prior to moving changes into production and shall be a simulation of the production environment, with appropriate provider, enrollee, reference, claim, encounter, TPL, and any other data necessary to support all TCMIS processing and reporting functions.

A.2.8.2.4.5 The Contractor shall create standard regression test scenarios that test the functionality of the system using standardized real case test scenarios that can be reused for each regression test.

A.2.8.2.4.6 The Contractor shall allow for unique identification of test claims, test providers, and test enrollees.

A.2.8.2.4.7 Provide for an integrated testing environment that shall accept changes to eligibility and enrollment that shall then be tested and followed through a simulation of the production environment.

A.2.8.2.4.8 Provide and maintain an integrated testing environment that shall process claims and encounters that shall then be tested and followed through a simulation of the production environment.

A.2.8.2.4.9 Provide and maintain an integrated testing environment that shall allow for complete testing of special projects.

A.2.8.2.4.10 Provide for an integrated testing environment that shall allow for complete testing of other additional priorities.

A.2.8.2.5 The Contractor shall be required to use Bureau authorized testing tools beginning May 1, 2010 (or operations start date).

A.2.8.2.6 The Contractor shall use version control procedures.

A.2.8.2.7 The Contractor shall update schedules to facilitate tests.

A.2.8.2.8 The Contractor shall track discrepancies.

A.2.8.2.9 The Contractor shall facilitate regression test analysis.

A.2.8.2.10 The Contractor shall develop the enhanced test environment with the ability to branch the code into multiple environments and merge back into a full systems test environment.

A.2.8.2.11 The Contractor shall provide controls to maintain the integrity of the test data in

the multiple testing environments.

A.2.8.2.12 The Contractor shall provide the Bureau with online access to the multiple testing environments and ensure the testing environments are available to all appropriate Contractor and Bureau-designated staff.

A.2.8.2.13 The Contractor shall produce and review all control reports generated for each test update and processing cycle.

A.2.8.2.14 The Contractor shall perform TCMIS testing through the following test levels in the order specified, unless exception is granted for emergency events:

1) Unit testing
2) Model Office
3) Integration testing
4) UAT Staging
5) UAT and Regression testing

A.2.8.2.15 To facilitate emergency changes (called “priority” or “non-scheduled”) without interrupting the testing of normal changes, one of the integration test environments shall be allocated for emergency changes. Some emergency changes may skip system and/or acceptance level testing, depending on the type of change and the urgency of the change.

A.2.8.2.16 The Contractor shall provide at least four (4) integrated test facility regions. The purpose of providing multiple test regions is to ensure the stability of the test data when major enhancements are being tested, without having to freeze the test data at the expense of other system changes.

A.2.8.3 <u>Business Process Functionality Contractor Requirements:</u>

A.2.8.3.1 The Contractor shall provide the capability and procedures to allow for multiple software modifications concurrently to include, at a minimum, the following:

A.2.8.3.1.1 Ensure that all libraries containing code, data, and software components utilized for testing shall be separate and distinct in all cases from those in production;

A.2.8.3.1.2 Ensure that the multiple test environments shall allow for different phases of testing to be conducted concurrently;

A.2.8.3.1.3 Assure accurate testing of maintenance and modifications;

A.2.8.3.1.4 Provide capability to link to a particular project and associate multiple existing projects;

A.2.8.3.1.5 Provide migration procedures for moving multiple projects into production involving common software modules; and

A.2.8.3.1.6 Update the system audit trail to ensure accurately promoting modified software for multiple projects.

A.2.8.3.2 The Contractor shall review, validate, and submit for Bureau approval output produced from the multiple test environments. All applications shall be thoroughly tested to prove that they perform all specified functions correctly and maintain data integrity under all expected conditions.

A.2.8.3.3 The Contractor shall use the walk-through method for "walking through the material" with the Bureau, when requested. This method, when used for reviewing applications, may detect inconsistencies between the specifications and the application, Bureau standards and the application or within the application itself.

A.2.8.3.4 The Contractor shall report on the impact of test cycles and compare those results to the actual processing results.

A.2.8.3.5 The Contractor shall keep all test outputs separate from routine TCMIS outputs, and clearly label all outputs as test outputs.

A.2.8.3.6 The Contractor shall produce and review all control reports generated for each test update and processing cycle.

A.2.8.3.7 The Contractor shall develop test data, including, but not limited to, claims/encounter data and eligibility/enrollment data at the direction of the Bureau. The testing processes shall include all forms of data submission (e.g., interactive, batch, data entry).

A.2.8.3.8 The Contractor shall provide all application documentation for review and approval prior to subsequent use in development or maintenance work, or prior to delivery to the Bureau.

A.2.8.3.9 The Contractor shall conduct testing reviews with reviewers who are knowledgeable of the information upon which the document under review is based and who have sufficient technical knowledge to understand the document.

A.2.8.3.10 The Contractor shall document all reviews. The reviewers shall, at a minimum, consider correctness, conformance to Bureau standards, user specifications, and adherence to generally accepted best practices (such as structured development, efficiency, and maintainability). Review documentation shall identify the item reviewed, the author, the reviewer(s), the date reviewed, and the disposition of the review (approval or rejection with reasons). Documentation of approval shall be retained as long as the approved version of the document is in production status.

A.2.8.3.11 The Contractor shall create one (1) Test Plan for the project and one (1) Test Plan for each level of testing for each application. The test plan for the project shall be called a Test Management Plan while the test plans for each level of testing take on the level name, such as System Test Plan. Test Plans shall specify the scope, resources, schedule of testing activities and the method or approach to testing that the project team shall use. Industrial, Electrical and Electronic Engineers (IEEE), a standard setting organization, identifies the

following as subjects to be addressed in a Test Plan:

A.2.8.3.11.1 Test Items

A.2.8.3.11.2 Features to be Tested

A.2.8.3.11.3 Features Not to be Tested

A.2.8.3.11.4 Testing Approach

A.2.8.3.11.5 Testing Item Pass/Fail Criteria

A.2.8.3.11.6 Suspension Criteria and Resumption Requirements

A.2.8.3.11.7 Test Deliverables

A.2.8.3.11.8 Testing Tasks

A.2.8.3.11.9 Environmental Needs

A.2.8.3.11.10 Responsibilities

A.2.8.3.11.11 Staffing Needs

A.2.8.3.11.12 Training Needs

A.2.8.3.11.13 Testing Schedule

A.2.8.3.11.14 Risks and Contingencies

A.2.8.3.11.15 Approvals for Testing

A.2.8.3.12 The Contractor shall develop Test Management Plans that address management of the test process for the project and according to test plan standards.

A.2.8.3.13 A Test Management Plan shall address each test environment individually, with sections for Unit Test Plan, System Test Plan, and Integration Test Plan.

A.2.8.3.14 A Test Management Plan shall address the objectives, approach, procedures, and techniques used in each test environment.

A.2.8.3.15 A Test Management Plan shall address the environment, including infrastructure safeguards, test condition level and format, source and management of test data, and test validation procedures.

A.2.8.3.16 A Test Management Plan shall also include instructions for detailed testing of the TCMIS interfaces resulting in the verification that data was transmitted and received in accordance with functional requirements.

A.2.8.3.17 A Test Management Plan shall outline resource requirements that, at a minimum, include information pertaining to personnel, hardware, and testing tools.

A.2.8.3.18 A Test Management Plan shall outline requirements to develop targeted Test Cases that document the preconditions (what relevant data shall exist at the start of the test case execution), inputs, and the expected results.

A.2.8.3.19 The Contractor shall provide a library of de-identified model office and integration test cases that may be selected and modified by the user for testing.

A.2.8.3.20 The Test Case Library shall have search capability that is cross referenced to the logic/edit that test case is designed to test.

A.2.8.3.21 The regression and performance Test Case Library shall have a statistically significant sample size so the Bureau can be assured that they are selecting a sample size that represents the entire population of scenarios within a ninety-nine percent (99%) confidence interval.

A.2.8.3.22 Test Documentation shall be reviewed and approved prior to testing.

A.2.8.3.23 The Contractor shall record Test Results in a form that can be validated after the test case is executed.

A.2.8.3.24 Test Results shall be reviewed to verify correctness.

A.2.8.3.25 The Contractor shall retain Test Documentation as long as the tested version of the application remains in production.

A.2.8.3.26 The Contractor shall perform Unit and Model Office Testing, which is dynamically testing all new or modified software units (e.g. modules, programs, job streams, scripts) to shall prove that the unit performs all specified functions correctly and maintains data integrity under all specified conditions.

A.2.8.3.27 Unit and Model Office Test Results shall be recorded in a form that can be validated after the test case is executed.

A.2.8.3.28 The Contractor shall develop a Unit and Model Office Test Plan prior to unit testing.

A.2.8.3.29 The Unit and Model Office Test Plan shall include, at a minimum:

A.2.8.3.29.1 Test conditions and expected results for the program's main functions;

A.2.8.3.29.2 Test cases;

A.2.8.3.29.3 Preconditions, both expected and unexpected (what relevant data exists at the start of the test case execution);

A.2.8.3.29.4 Inputs (both valid and invalid);

A.2.8.3.29.5 Boundary conditions such as loop exit criteria;

A.2.8.3.29.6 Expected results for test cases and units;

A.2.8.3.29.7 Unit Test Documentation (e.g., plans, input data, execution scripts); and

A.2.8.3.29.8 Test results that shall be retained as long as the tested version of the module remains in production.

A.2.8.3.30 The Contractor shall develop an Integration Test Plan prior to integration testing

according to test plan standards.

A.2.8.3.31 The Contractor shall perform System Tests on all new and significantly modified applications and verify before release of the application to the Bureau.

A.2.8.3.32 System tests shall prove that the application functions correctly as integrated.

A.2.8.3.33 System Tests for any functionality shall be completed before regression testing for that functionality begins.

A.2.8.3.34 The Contractor shall develop a System Test Plan prior to system testing according to test plan standards. System Test Results shall be recorded in a form that shall have the capability to be validated after the system test case is executed.

A.2.8.3.35 The Contractor shall develop the test environments as requested in this section for testing based on business functionality and Bureau defined testing strategy/criteria. Acceptance Tests shall be performed by the Bureau or designated staff.

A.2.8.3.36 The Contractor shall provide an enhanced test environment to support the user testing that allows the Bureau and the Contractor to monitor the accuracy of the TCMIS and test proposed changes to the system by processing test claims and other transactions through the system without affecting normal operations. The full system and regression testing environments shall mirror production in its files, databases, processing, and reporting. The full system and regression test environments shall allow for end-to-end testing, (e.g., from claims entry through the financial and reporting cycles). The user acceptance testing shall be incorporated into the integration, full system, and regression testing environments.

A.2.8.3.37 The Contractor shall provide the ability to execute impact analysis testing of any proposed change.

A.2.8.3.38 The Contractor shall provide the ability to create “what-if” scenarios and compare results between scenarios in a test environment.

A.2.8.3.39 The Contractor shall provide testing environments that allow users to create and edit provider, recipient, and MCC records for testing.

A.2.8.3.40 The Contractor shall ensure the continuity of on-going business processes before, during and after implementation of the enhanced test environment.

A.2.8.4 <u>Contractor Deliverables:</u>

A.2.8.4.1 Establish enhanced test environments.

A.2.8.4.2 Customize enhanced test environments for the Bureau.

A.2.8.4.3 Integrate enhanced test environments with interChange.

A.2.8.4.4 Implement source code control and version control software in the enhanced test environment.

A.2.8.4.5 Acquire Bureau acceptance and approval of output produced from the multiple test environments.

A.2.8.4.6 Facilitate Bureau online access to the multiple testing environments.

A.2.8.4.7 Acquire Bureau acceptance and approval of control reports.

A.2.8.4.8 Obtain Bureau acceptance and approval of test data.

A.2.8.4.9 Obtain Bureau acceptance and approval of Test Plans (Test Management and System Test).

A.2.8.4.10 Obtain Bureau acceptance and approval of Unit and Model Office Test Plans.

A.2.8.4.11 Obtain Bureau acceptance and approval of Integration Test Plans.

A.2.8.4.12 Obtain Bureau acceptance and approval of testing of all four (4) integration testing environments.

A.2.8.4.13 Complete and Implement Enhanced Testing Environments.

A.2.8.4.14 Convert the current UAT and Regression environment to a regression test environment.

A.2.9 Enhancement #7 – Business Process Modeling and Improvement

A.2.9.1 Summary

The Contractor shall staff a Business Process Modeling and Improvement section or unit whose main function shall be to develop and maintain a complete and detailed business process model of the Bureau and Contractor business processes for the twenty-two (22) month period of this enhancement. This shall include Bureau direct business processes and indirect business processes, such as DHS eligibility, Program Integrity fraud and abuse investigations, Office for Information Resources (OIR) interfaces, and other indirect business processes. The Bureau plans to focus on internal processes, but wants the capability to assess the indirect businesses. The Bureau requires the process analysis and modeling include Activity Based Costing (ABC). It is difficult to improve the current Bureau business processes with a lack of proper documentation.

A.2.9.2 System Functionality Contractor Requirements:

A.2.9.2.1 The Contractor shall provide their own business process modeling software with viewing and reporting capabilities, as approved by the Bureau.

A.2.9.2.2 The software shall be able to create a visual depiction of the business processes

documented.

A.2.9.2.3 The Contractor shall supply the Bureau with ten (10) licenses of the software the Contractor is using.

A.2.9.2.4 The Contractor shall publish the process modeling and activity based costing documentation so that it can be easily viewed and printed by Bureau staff.

A.2.9.3 Business Process Functionality Contractor Requirements:

A.2.9.3.1 The Contractor shall provide staff that are experienced and proficient in process modeling methods and software and that have performed process modeling for a State MMIS or similar scale system design, development and implementation projects for a government or private-sector health care payer.

A.2.9.3.2 The Contractor shall perform an analysis to document the business function hierarchy of the Bureau, specifying the critical business processes performed, identifying functions unique to TennCare and mapping those functions to the specific organizations. Throughout this analysis, good practices and processes of other organizations may be identified to assist in maturing similar TennCare processes.

A.2.9.3.3 The Contractor shall perform business process modeling to identify and document the business process of the Bureau and the Contractor.

A.2.9.3.4 The Contractor shall successfully provide a comprehensive, detailed analysis of current Bureau and Contractor business processes.

A.2.9.3.5 Identify potential restructuring of business processes, existing information systems, potential integration between systems, potential integration with other State systems and potential integration with new or emerging technologies.

A.2.9.3.6 This comprehensive analysis should include, but not be limited to, the business processes and business areas as defined in the Medicaid Information Technology Architecture (MITA).

A.2.9.3.6.1 Define goals of all business processes.

A.2.9.3.6.2 Identify inputs to each business process.

A.2.9.3.6.3 Identify outputs to each business process.

A.2.9.3.6.4 Describe what activities are performed, who performs them, and in what order they are performed, for each step in the business process.

A.2.9.3.6.5 Identify all resources, such as hardware, software and personnel, necessary to complete each business process.

A.2.9.3.6.6 Identify what monitoring takes place.

A.2.9.3.6.7 Outline the Work Plan and language or methodology to be used (within State standards.)

A.2.9.3.7 The Contractor shall include an assessment of existing computing platforms and information systems, including manual processes and automated processes, to determine their future effectiveness in meeting the needs of the Bureau.

A.2.9.3.8 The Contractor shall include an assessment of the abilities to enhance the electronic filing and imaging of documents with the current information system.

A.2.9.3.9 The Contractor shall determine a migration path for current information systems that allows them to operate in a more user-friendly and efficient environment.

A.2.9.3.10 The Contractor shall develop cost/benefit recommendations regarding various projects and initiatives.

A.2.9.3.11 The Contractor shall develop an appropriate quality assurance review process.

A.2.9.3.12 The Contractor shall identify areas where the use of information technology could improve the efficiency and effectiveness of the TCMIS in providing service to the public. Particular attention shall be paid to the use of telephone systems, the use of forms and the use of the web/Internet.

A.2.9.3.13 The Contractor shall provide a detailed description of the methods by which the Contractor plans to accomplish all of the work discussed for the Business Process Modeling requirement, beginning with a brief statement demonstrating an understanding of the nature and desired results of the project.

A.2.9.3.14 The Contractor shall provide a description of the basic concept and proposed methodology for accomplishing the necessary tasks outlined.

A.2.9.3.15 The Contractor shall provide the overall project strategy, demonstrating the manner in which all work elements shall be combined into the production of the desired results.

A.2.9.3.16 The Contractor shall provide a clear vision of what the future business processes shall look like, including step-by-step directions, forms to be used, procedures to be followed and the entity that would utilize these steps.

A.2.9.3.17 The Contactor shall recommend application solutions that address high volume, labor intensive activities, including solutions that minimize keystrokes and potential errors.

A.2.9.3.18 The Contractor shall provide solutions that ensure that all appropriate Bureau staff has access to all information, data and processes that are documented during the business process effort.

A.2.9.3.19 The Contractor shall provide evaluations, with supporting recommendations, on the proper role and utilization of the Internet in meeting the needs of TennCare enrollees and the general public's contact with TennCare operations.

A.2.9.3.20 The Contractor shall provide a clear vision of what type of integrated Medicaid

system requirements would be necessary to efficiently, and effectively, automate the refined business practices.

A.2.9.3.21 The Contractor shall define the possible Business Process Documentation Methodologies, such as Swim Lane diagrams, Work Flow diagrams, Pareto diagrams, Enterprise diagrams, and provide an assessment of each and a recommendation of which methodology they recommend.

A.2.9.3.22 The Contractor shall maintain and update the business process modeling on an annual basis and integrate with the Change Management Process.

A.2.9.3.23 The Contractor shall integrate Activity Based Costing into the process model, which includes:

A.2.9.3.23.1 Analyzing activities

A.2.9.3.23.2 For Bureau processes, gathering current direct costs of the Bureau, as provided by the Bureau, and identify expected costs of alternative solutions. For Contractor processes, identify current costs to the Bureau and identify expected costs of alternative solutions.

A.2.9.3.23.3 Tracing costs to activities

A.2.9.3.23.4 Establishing output measures

A.2.9.3.23.5 Analyzing costs

A.2.9.3.23.6 The Contractor shall utilize Unified Modeling Language (UML) and use cases for the Business Process Documentation.

A.2.9.4 <u>Contractor Deliverables:</u>

A.2.9.4.1 Establish Business Process Improvement Unit.

A.2.9.4.2 Provide overall project strategy and methodology.

A.2.9.4.3 Procure Business Process Modeling software, in accordance with Section C.3 Payment, Paragraph (f) Hardware, Software and Maintenance.

A.2.9.4.4 Obtain Bureau acceptance and approval of Contractor's assessment and recommendation on Business Process Documentation Methodologies utilizing the Contractor's Bureau approved business process modeling software, including the incorporation of Activity Based Costing.

A.2.9.4.5 Provide assessment of mailroom activities.

A.2.9.4.6 Provide assessment of electronic filing and imaging abilities.

A.2.9.4.7 Provide assessment of existing information systems.

A.2.9.4.8 Provide a comprehensive, detailed Analysis of Bureau's business processes.

A.2.9.4.9 Provide a comprehensive, detailed Analysis of Facilities Manager's business processes.

A.2.9.4.10 Obtain Bureau acceptance and approval of Contractor's assessment of mailroom activities.

A.2.9.4.11 Obtain Bureau acceptance and approval of Contractor's assessment of the electronic filing and imaging abilities.

A.2.9.4.12 Obtain Bureau acceptance and approval of Contractor's assessment of existing information system.

A.2.9.4.13 Obtain Bureau acceptance and approval of Contractor's comprehensive, detailed Analysis of Bureau's business processes.

A.2.9.4.14 Obtain Bureau acceptance and approval of Contractor's comprehensive, detailed Analysis of Contractor's business processes.

A.2.9.4.15 Provide quality assurance review process activities.

A.2.9.4.16 Provide Internet utilization evaluation and recommendations.

A.2.9.4.17 Provide cost-benefit recommendations relating to each Analysis and Assessment.

A.2.9.4.18 Complete and submit for Bureau approval, the Business Process Modeling Enhancement and outline procedures for maintaining Business Process Modeling.

A.2.9.4.19 Provide a thorough Activity Base Costing analysis with each assessment and recommendation.

A.2.9.5 <u>Bureau Responsibilities:</u>

A.2.9.5.1 Review Contractor's assessment of Mailroom activities.

A.2.9.5.2 Review Contractor's recommendations for strategy and methodology to accomplish the Business Process Modeling Enhancement.

A.2.9.5.3 Review Contractor's recommendations for electronic filing and imaging.

A.2.9.5.4 Review Contractor's recommendations for existing information system

A.2.9.5.5 Review Contractor's analysis of Bureau's business processes.

A.2.9.5.6 Review Contractor's analysis of Contractor's business processes

A.2.9.5.7 Review and approve that the Business Process Modeling Enhancement has been successfully completed and includes an outlined plan to maintain and

update the model.

A.2.9.5.8 Provide direct cost information as necessary to support business process cost analysis

A.2.10 Enhancement #8 – Long-Term Care Reform

A.2.10.1 Summary

The Contractor shall support the Bureau's implementation of the Long Term Care CHOICES project. The Contractor shall review the proposed changes associated with the Long Term Care CHOICES project and identify changes needed in the TCMIS. Contractor shall coordinate with the Bureau to identify, test and implement the necessary TCMIS updates.

The Long-Term Care Community CHOICES Act of 2008 was approved by the Tennessee General Assembly on May 20, 2008 to be effective July 1, 2008 and was signed by Governor Phil Bredesen on the 17th of June, 2008. It is expected this program will expand existing Home and Community Based Services or HCBS Waiver program for persons who are elderly and/or adults statewide. The federal government has not given the final approval for proposed changes, however approval is anticipated. The first phase calls for the roll-out to the Middle Tennessee region to incorporate functionality to support the LTC changes; to begin six months after receipt of federal approval of the plan. The second phase will include a roll-out to the East Tennessee region and additional reporting functionality, targeting six months after the Phase 1 deployment. A third phase will include a roll-out to the West Tennessee region and may also introduce additional functionality based on discovery in phase 1 and 2 and/or additional CMS requirements, targeting deployment six months after deployment of Phase 2. The Bureau also anticipates a three month post-implementation verification and close down of the project.

A.2.10.2 System Functionality Contractor Requirements

A.2.10.2.1 The Contractor shall enhance the existing TCMIS subject to approval of the Bureau to support the requirements defined for implementation of the LTC CHOICES program.

A.2.10.3 Business Process Functionality Contractor Requirements

A.2.10.3.1 The Contractor shall ensure the continuity of on-going business processes before, during and after implementation to the LTC CHOICES product.

A.2.10.4 Contractor Deliverables

A.2.10.4.1 Project Charter.

A.2.10.4.2 Requirements Documentation.

A.2.10.4.3 Test Plan.

A.2.10.4.4 Design specifications.

A.2.10.4.5 Test Cases and outcomes.

A.2.10.4.6 Implementation of system changes.

A.3 TCMIS Business Process and Functional Requirements

A.3.1 Functional Areas and Business Processes

Listed below are TCMIS functional areas and operations processes:

Integration and Interfaces
Eligibility and Enrollment
Correspondence, Letters and Notices
Complaints/Grievances/Appeals
Benefit Packages
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Medicare Buy-In
Accounting/Financial/Premium Management
Drug Rebate
Claims/Encounter Claims
Third Party Liability (TPL)
Reference
Long Term Care Business Unit
Program Integrity/Surveillance and Utilization Review (SUR)/ Fraud and Abuse
Managed Care
Management and Administrative Reporting
Provider
Electronic Data Interchange (EDI)
Facilities Manager General Operations
Turnover Tasks

A.3.2 Integration and Interfaces

The interChange (iC) TCMIS receives and exchanges information from various resources. All integrated interfaces shall comply with HIPAA standards and transaction code sets rules. The Contractor shall maintain the TCMIS interfaces and system design according to the guidelines set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and shall act upon any technological updates, and/or changes in business processes or business relationships, as directed by the Bureau.

The external interface files are used in the following functional areas. (A diagram is provided in Section A.3.2.3)

Accounting

Claims and Encounters

Drug Rebate

EPSDT

Eligibility

Enrollment

Financial

Fraud and Abuse (SUR)

Management and Administrative Reporting (MAR)

Medicare Buy-In

Premium Processing (Oracle Financials)

Provider

Reference

TPL

EDI

A summary of the existing interfaces is presented within each functional area.

The Department of Human Services (DHS) shall be implementing their (Vision Integration Platform (VIP) project, which shall cause revisions to be needed in the current eligibility interface processes.

A.3.2.1 Interface Listing

A specific list of already developed interfaces is listed in the following table. The Contractor is expected to maintain the interfaces as needed for TCMIS operations.

Functional Area	External Entity / Interface	Entity Type	Inbound/ Outbound
Accounting	STARS History File – Check Number, Check Date	Finance and Administration Accounts – STARS	Inbound
Accounting	STARS History File – Bureau of TennCare Financial Activity	Finance and Administration Accounts – STARS	Inbound

Functional Area	External Entity / Interface	Entity Type	Inbound/ Outbound
Accounting	Vendors	Finance and Administration Accounts – STARS	Inbound
Accounting	interChange Payment Request	interChange Financial	Inbound
Accounting	Payment Voids	interChange Financial	Inbound
Buy-In	Part A Billing Tape	CMS	Inbound
Buy-In	Part A Premium Tape	CMS	Outbound
Buy-In	Part B Billing Tape	CMS	Inbound
Buy-In	Part B Premium Tape	CMS	Outbound
Buy-In	MMA Part D	CMS	Outbound
Buy-In	MMA Part D Response File	CMS	Outbound
Drug Rebate	Centers for Medicare and Medicaid Services Labeler File	CMS	Inbound
Drug Rebate	Centers for Medicare and Medicaid Services Rate File	CMS	Inbound
Drug Rebate	Drug Rebate File for CMS	CMS	Outbound
Drug Rebate	Data Niche file interface	Data Niche	Outbound
Drug Rebate	Electronic PQAS	CMS	Inbound
Drug Rebate	Electronic ROSI	CMS	Inbound
Drug Rebate	Pharmacy Benefits Manager (PBM) Claims Payment Detail File	Pharmacy Benefits Manager	Inbound
EDI/Claims	BCBS Part A Medicare Crossover Claim Type 17	BCBS Crossover Intermediary – Part A or B	Inbound
EDI/Claims	BHO UB92 Claims Formats – 837I	Each BHO	Inbound
EDI/Claims	BHO Capitation Fees – Claim Type 19 – 820	Each BHO	Outbound
EDI	BHO Daily Enrollment/Eligibility File – 834/271U	Each BHO	Outbound

Functional Area	External Entity / Interface	Entity Type	Inbound/ Outbound
EDI/Claims	MCC CMS Claims Formats – 837P	Each MCO and BHO	Inbound
EDI/Claims	MCO UB92 Claims Formats – 837I	Each MCO	Inbound
EDI/Claims	MCO Capitation Fees – Claim Type 19 – 820	Each MCO	Outbound
EDI	MCO Enrollment Files – 834/271U	Each MCO	Outbound
EDI/Claims	Part B Medicare Crossover Claim Type 18	Cigna Crossover Intermediary – Part B	Inbound
EDI	DCS (Dept. of Children's Services) Remittance Advice File	Department of Children's Services	Outbound
EDI/Claims	Department of Children's Services File – 837P	Department of Children's Services	Inbound
EDI	Dental Benefits Manager Dental Encounters	DBM	Inbound
EDI/Claims	Dental Benefits Manager Eligibility File 834	DBM	Outbound
EDI/Claims	Dental Benefits Manager Premium Payment File – 820	DBM	Outbound
EDI	HCBS Providers Remittance Advice	HCBS Waiver Service Providers	Outbound
EDI	HCBS Providers – 837I	HCBS Waiver Service Providers	Inbound
EDI	HCBS Providers – 837P	HCBS Waiver Service Providers	Inbound
EDI	PACE Remittance Advice - 835	Program of All-inclusive Care for Elderly	Outbound
EDI	Pharmacy Benefits Manager (PBM) Eligibility File – 834	PBM	Outbound
EDI	Medi-Fax, Passport, WebMD Eligibility Inquiry	VANs	Inbound
EDI	Medi-Fax Passport, WebMD Eligibility Inquiry Response	VANs	Outbound
EDI/Claims	Palmetto – Durable Medical Equipment	Palmetto Crossover Intermediary – Part A	Inbound
Eligibility	BCBS Medicare Claim Number (HICN) Cross Reference file	BCBS Crossover Intermediary – Part A or B	Outbound
Eligibility	Cigna Medicare Claim Number (HICN) Cross Reference file	Cigna Crossover Intermediary – Part B	Outbound

Functional Area	External Entity / Interface	Entity Type	Inbound/ Outbound
Eligibility	DCS MCO Monthly Extract File	DCS	Outbound
Eligibility	1610 manual Transactions	DHS	Inbound
Eligibility	ACCENT – Medicaid Eligibility	DHS	Inbound
Eligibility	ACCENT – Reconciliation	DHS	Inbound
Eligibility	ACCENT – Referral	DHS	Inbound
Eligibility	Accent Response to Address Match	DHS	Inbound
Eligibility	TennCare to Accent Address File	DHS	Outbound
Eligibility	ARAD Notice File	DHS	Outbound
Eligibility	ARAD Summary Errors File	DHS	Outbound
Eligibility	ARAD Term File	DHS	Outbound
Eligibility	AS/400 – Presumptive Eligibility	DHS	Inbound
Eligibility	BENDEX	DHS	Inbound
Eligibility	DCS Immediate (Presumptive) Eligibility file	DHS	Inbound
Eligibility	Dept. of Children's Services (DCS) Presumptive Eligibility Return file	DHS	Outbound
Eligibility	Department of Human Services (DHS) Daily Individual Extract (Initial)	DHS	Inbound
Eligibility	Department of Human Services (DHS) Daily Ineligibles	DHS	Inbound
Eligibility	Matched Input with RID Discrepancies	DHS	Inbound
Eligibility	Medicaid Benefit Issuance	DHS	Inbound
Eligibility	Medicaid Pending/Denied Individual Extract Pending file	DHS	Inbound
Eligibility	Monthly Waiver Recon	DHS	Outbound
Eligibility	Online Appointment Tracking System (OATS) thirty (30) Day	DHS	Outbound

Functional Area	External Entity / Interface	Entity Type	Inbound/ Outbound
	Notice (Term) File		
Eligibility	Online Appointment Tracking System (OATS) ninety (90) Day Merged File	DHS	Outbound
Eligibility	Online Appointment Tracking System (OATS) ninety (90) Day Notice (Term) File	DHS	Outbound
Eligibility	Online Appointment Tracking System (OATS) Initial Return File	DHS	Outbound
Eligibility	Patient Liability	DHS	Inbound
Eligibility	Sorted Social Security Number	DHS	Outbound
Eligibility	TennCare Referral Eligibility Errors	DHS	Outbound
Eligibility	TennCare Referral Syntax Errors	DHS	Outbound
Eligibility	TennCare Responses	DHS	Outbound
Eligibility	SDX /SSI Recon Processing	DHS/Social Security Administration	Inbound
Eligibility	SDX Daily Update File	DHS/Social Security Administration	Inbound
Eligibility	Department of Corrections (DOC) /Prisoner	Department of Corrections	Inbound
Eligibility	DOH Eligibility Inquiry Response	DOH	Outbound
Eligibility	DOH Vital Statistics Death Records	DOH	Inbound
Eligibility	DOH Outreach File (Children Under 21) -	DOH	Outbound
Eligibility	DOH Pregnant Women File	DOH	Outbound
Eligibility	Mental Health & Developmental Disabilities Interface File transactions	MHDD	Inbound
Eligibility	State Judicial Only File	MHDD	Outbound
Eligibility	COBA Eligibility Extract	Palmetto Crossover Intermediary – Part A	Outbound
Eligibility	ProLaw Daily Appeals File	Keystone Peer Review	Inbound
Eligibility	ProLaw On Request Appeals File	Keystone Peer Review	Inbound

Functional Area	External Entity / Interface	Entity Type	Inbound/ Outbound
Enroll	Behavioral Health Organization Error Judicial File	Each BHO	Outbound
Enroll	Magellan Assessment File	Each BHO	Inbound
Enroll	Magellan Assessment File	Each BHO	Outbound
Enroll	Magellan Enrollment Files – 834	Each BHO	Inbound
Enroll	TennCare DCS (Exiting) Custody File	DCS	Inbound
Enroll	Children in Custody Files -	Each BHO	Outbound
Enroll	Children in Custody Files -	MCO 011	Outbound
Enroll	Dept of Children's Services (DCS) (Exiting) Custody Ineligible File	DCS	Outbound
Enroll	Dept of Children's Services (DCS) (Exiting) Custody No Date of Birth	DCS	Outbound
Enroll	Department of Children's Services (DCS) (Exiting) Custody No Match	DCS	Outbound
Enroll	Department of Children's Services (DCS) (Exiting) Custody No Name	DCS	Outbound
Enroll	DCS (Exiting) Custody Wrong Social Security Number File	DCS	Outbound
Enroll	TennCare DCS Regina (Entering) File	DCS	Inbound
Enroll	Department of Children's Services Regina (Entering) Ineligibles	DCS	Outbound
Enroll	DCS Regina (Entering) No Match	DCS	Outbound
Enroll	DCS Incarceration File	DCS	Inbound
Enroll	MCO Enrollment Files - 834	Each MCO	Inbound
Enroll	Dept of Personnel (DOP) Response File	DOP	Inbound/Outbound
EPSDT	BHO EPSDT Screening File	Each BHO	Outbound

Functional Area	External Entity / Interface	Entity Type	Inbound/ Outbound
EPSDT	MCO EPSDT Screening File	Each MCO	Outbound
EPSDT	Immunization Registry	Department of Health	Inbound
EPSDT	Immunization Request	Department of Health	Outbound
F & A	State Wage File	Program Integrity Unit	Inbound
F & A	SSA TPL Files (Death Match)	DHS	Inbound
Financial	Accounts Receivable File – STARS Format	STARS	Outbound
Financial	Payment File – STARS Format	STARS	Outbound
Financial	Refund Data File – STARS Format	STARS	Outbound
Financial	STARS History File	STARS	Inbound
MAR	Medicaid Statistical Information System (MSIS) All Other Claims File	CMS	Outbound
MAR	MSIS ELIGIBLE	CMS	Outbound
MAR	MSIS Inpatient Claims File	CMS	Outbound
MAR	MSIS Long Term Care Claims	CMS	Outbound
MAR	MSIS Pharmacy Claims File	CMS	Outbound
Premium	Bankruptcy File	Attorney General	Inbound
Premium	Case Additions/ Updates	DHS	Inbound
Premium	Am South Lock Box Premium Collection File	BANK	Inbound
Provider	Better Health Plan Provider Network Files	Each MCO	Inbound
Provider	Centers for Medicare and Medicaid Services Sanction Interface	Centers for Medicare and Medicaid Services	Inbound
Provider	Pharmacy License File	C & I; State Pharmacy Board	Inbound
Provider	State Licensure File	C & I State Pharmacy Board	Inbound

Functional Area	External Entity / Interface	Entity Type	Inbound/ Outbound
Reference	CIGNA/Medicare Rate Schedule	Cigna Crossover Intermediary – Part B	Inbound
Reference	Healthcare Common Procedure Coding System (HCPCS)	CMS	Inbound
Reference	First Data Bank (FDB)/Drug File	First Data Bank	Inbound
Reference:	ICD9 (Clinical Modification) Procedure & Diagnosis file	St Anthony	Inbound
TPL	Response Third Party Liability File	Each MCC	Inbound
TPL	Carrier Third Party Liability File	Each MCC	Outbound
TPL	Blue Care Resource Third Party Liability File	Each MCC	Outbound
TPL	EDB (Medicare Enrollment Database) – Inbound	CMS	Inbound
TPL	EDB (Medicare Enrollment Database) - Outbound	CMS	Outbound
TPL	PHP Commercial Carrier – 270	Commercial Insurers	Outbound
TPL	PHP Commercial Carrier – 271	Commercial Insurers	Inbound
TPL	County Jail Warm Body File	County Jails	Inbound
TPL	Department of Personnel File	Department of Personnel	Inbound
TPL	ACCENT Transactions	DHS	Inbound
TPL	Child Support (Absent Parent (IV-D)) File	DHS	Inbound
TPL	Child Support (Absent Parent (IV-D)) Request File	DHS	Outbound
TPL	DEERS/CHAMPUS Elig File	Department of Defense	Outbound
TPL	DEERS/ CHAMPUS Response File	Department of Defense	Inbound
TPL	State Health Plan/Tennessee Insurance System (SHP/TIS)	F &A Insurance Admin	Inbound
TPL	Employer Health Plan Data (Program Integrity Unit)	Program Integrity Unit	Inbound
TPL	State Prison Warm Body File	State Prison	Inbound
TPL	Public Assistance Reporting Info System (PARIS) Request	Veteran's Administration	Inbound

Functional Area	External Entity / Interface	Entity Type	Inbound/ Outbound
	File		
TPL	Public Assistance Reporting Info System (PARIS) Response	Veteran's Administration	Outbound
TPL	Estate recovery Not Found File	TPL	Inbound/Outbound
TPL	Estate Recovery Surviving Spouse -	TPL	Inbound/Outbound
TPL	Estate Recovery Matched	TPL	Inbound/Outbound
TPL	Estate Recovery Extract File	TPL	Inbound/Outbound
TPL	TPL Contractor Carrier file	TPL	Inbound
TPL	TPL Contractor Response File	TPL	Inbound

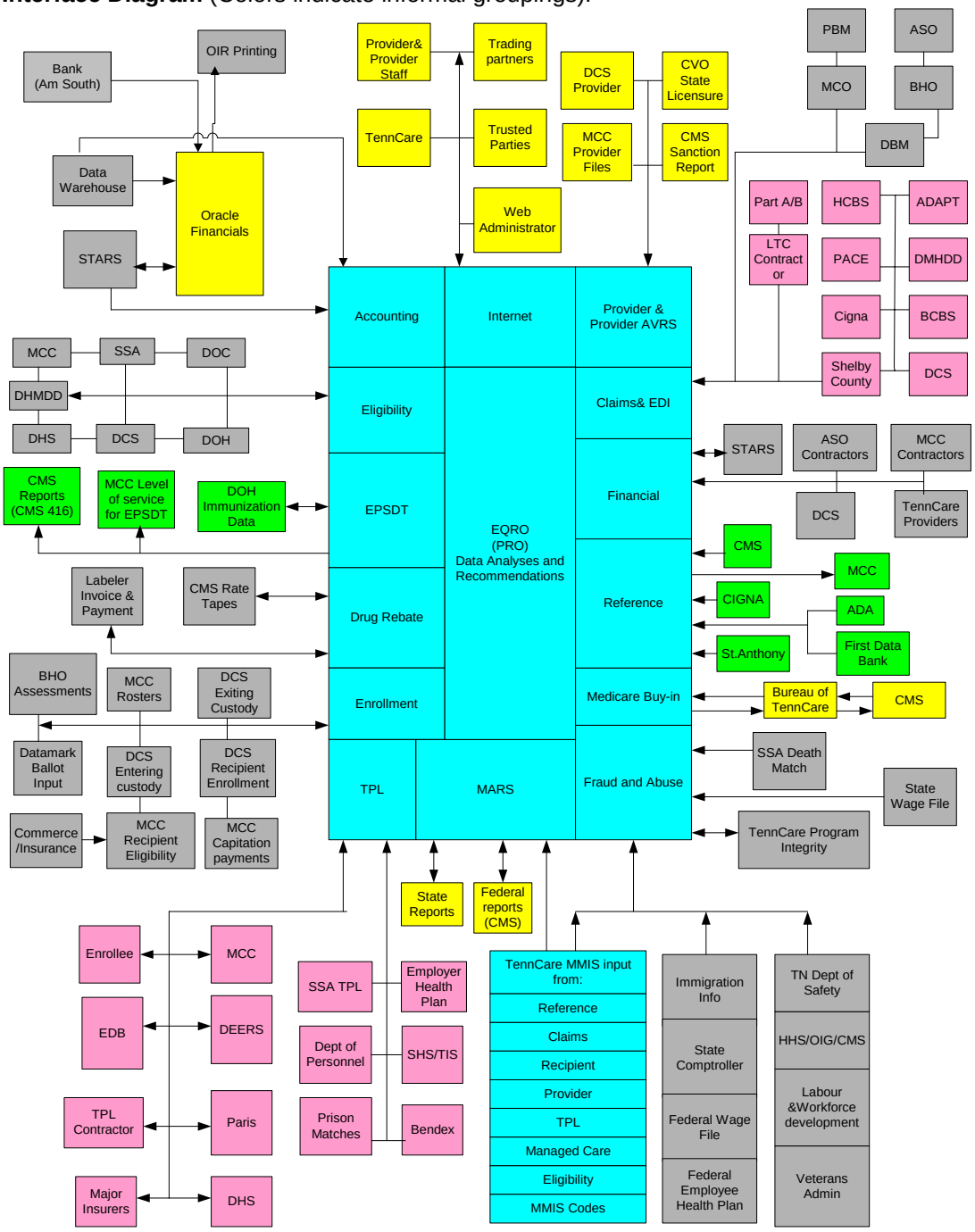
A.3.2.2 Modifications to Interfaces

If new interfaces are required to send and receive data and information from and to entities not currently in place or included in the enhancement section, the requirements shall be considered a modification to the existing system.

A.3.2.3 TCMIS Interface Diagram

The diagram depicted on the following page shows specific entities with whom the Bureau exchanges data. The various color groupings are used to indicate data exchanges focused within certain functional areas of TCMIS processing. The Contractor shall be required to maintain these interface processes.

Interface Diagram (Colors indicate informal groupings).



A.3.3 Eligibility and Enrollment

The Eligibility function accepts and maintains accurate, current and historical information on individuals who have applied for TennCare. The Enrollment function determines MCC assignments and generates enrollment rosters. The enrollment data is also used for capitation processing and adjustments.

Eligibility determination for both Medicaid and TennCare Waiver eligibility is performed at the DHS under a “single point of intake” policy. Add and update transactions received from DHS are processed in the interChange TCMIS. The Bureau also receives eligibility information from the Department of Mental Health and Developmental Disability (DMHDD) for two (2) other eligibility categories, “State Only” and “Judicial”.

The Eligibility and Enrollment required functions of the TCMIS include:

1) Accepting and managing eligibility of Title XVI of the Social Security Act, Title XIX of the Social Security Act (Medicaid), and other eligibility categories and processing updates from DHS, as well as from other State agencies.

2) Processing enrollment and disenrollment transactions for enrollees in MCC plans in the TennCare Program.

3) Processing recipient plan enrollment change requests.

4) Accepting and managing eligibility records received from DHS and other agencies during periods of open enrollment.

5) Processing eligibility data management and maintenance.

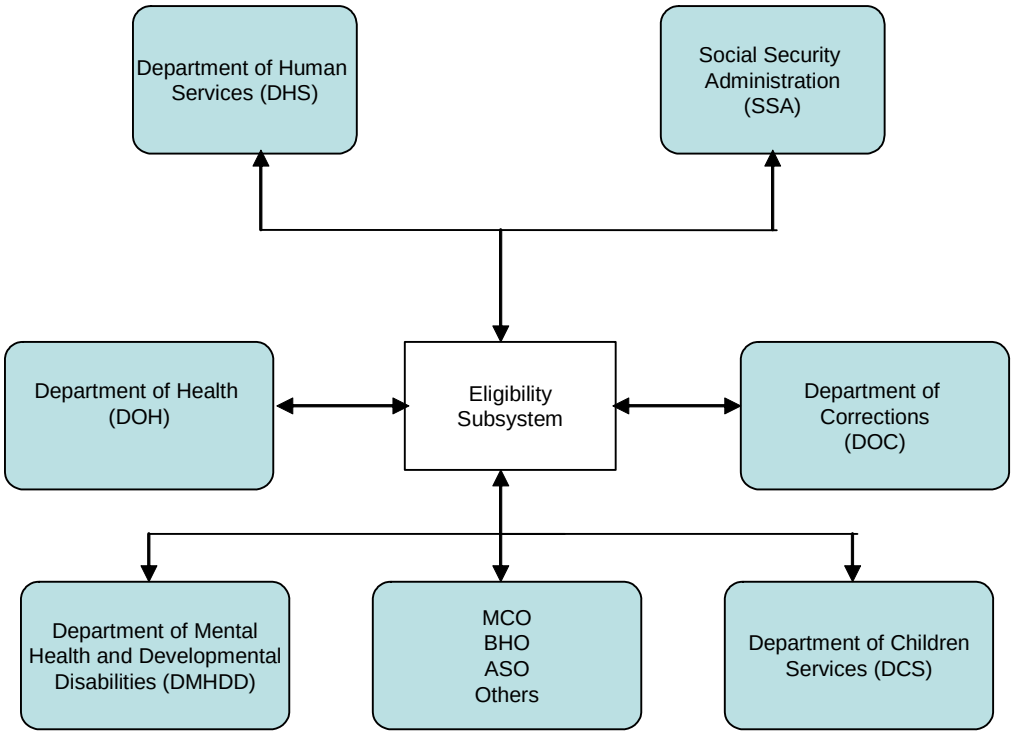
6) Processing updates from other agencies/external sources for other special needs populations.

7) Maintaining MCC enrollment and benefit information.

A.3.3.1 Eligibility Interface Diagram

The Contractor shall maintain the TCMIS Eligibility processes that utilize the data exchanged to and from the eligibility interfaces with which eligibility data is exchanged for TCMIS processes.

This Eligibility Interface Diagram depicts specific interfaces with which eligibility data is exchanged for TCMIS processes. The Contractor shall be expected to maintain the TCMIS Eligibility processes that utilize the data exchanged to and from these entities.



A.3.3.2 <u>Eligibility and Enrollment Contractor Requirements:</u>

A.3.3.2.1 Support and maintain access to the eligibility and enrollment database for all TCMIS transaction processing functions (e.g., claims processing, enrollment processing, capitation, premiums).

A.3.3.2.2 Maintain and capture the eligibility and enrollment component that contains demographic data as specified by State and federal requirements. Data collected includes, but is not limited to:

A.3.3.2.2.1 The enrollee's demographic information;

A.3.3.2.2.2 Eligibility category or categories;

A.3.3.2.2.3 Family affiliations;

A.3.3.2.2.4 LTC patient liabilities;

A.3.3.2.2.5 Eligibility date periods;

A.3.3.2.2.6 Prior authorization information;

A.3.3.2.2.7 Mental health assessment information;

A.3.3.2.2.8 Third-party resources;

A.3.3.2.2.9 Utilization limits status;

A.3.3.2.2.10 Co-payment status;

A.3.3.2.2.11 Restricted enrollee information;

A.3.3.2.2.12 Medicare eligibility;

A.3.3.2.2.13 Buy-In information;

A.3.3.2.2.14 Re-certification information;

A.3.3.2.2.15 Correspondence history;

A.3.3.2.2.16 Appeals;

A.3.3.2.2.17 Managed Care Contractor enrollment;

A.3.3.2.2.18 Primary Care Provider (PCP) information; and

A.3.3.2.2.19 Premium billing and payment history.

A.3.3.2.3 Update enrollee and eligibility data daily in appropriate date sequence as received from external eligibility sources (e.g., Department of Health (DOH), DHS, DCS, Division of Mental Retardation Services (DMRS), DMHDD, and the Social Security Administration (SSA)).

A.3.3.2.4 Maintain HIPAA compliance throughout the TCMIS.

A.3.3.2.5 Maintain current capabilities to create, update, and maintain an eligibility record.

A.3.3.2.6 Support data extracts and online queries for eligibility data for re-certification and status verification by other State agencies and process response files.

A.3.3.2.7 Maintain the capability to update, maintain, and allow online access to all historical and current enrollee data including, but not limited to: eligibility, MCC enrollment, demographic data, special programs, associated benefit packages, and audit trails with change data.

A.3.3.2.8 Support and maintain eligibility data including, but not limited to: termination updates, managed care plan enrollment data, and adjustments to capitation payments.

A.3.3.2.9 Maintain managed care plan enrollment updates online.

A.3.3.2.10 Maintain processes and enrollee data to support enrollee election or auto-assignment to MCCs.

A.3.3.2.11 Generate daily enrollment rosters to MCCs and other enrollment rosters as needed.

A.3.3.2.12 Support and process mass enrollment/disenrollment of all or selected recipients

from or into managed care plans, as defined by the Bureau.

A.3.3.2.13 Maintain the capability to accept enrollment of one (1) individual within a family on the same case number to a different managed care plan (e.g., the special needs child or DCS/SSI) than the other family members enrolled in a different MCC.

A.3.3.2.14 Maintain the capability to accept multiple eligibility categories for a unique enrollee identification number simultaneously with effective dates for each eligibility category.

A.3.3.2.15 System logic shall coordinate an enrollee's continued eligibility each time one (1) eligibility effective date segment and/or category terminates, following the Bureau business rules and/or policies, and not terminate coverage until all eligibility periods and/or categories are terminated.

A.3.3.2.16 Support online entry of demographic and eligibility information.

A.3.3.2.17 Maintain edits of inputs of enrollee demographic and eligibility information to ensure consistency and validity of information received through online data entry.

A.3.3.2.18 Maintain an audit trail of changes to demographics and eligibility information.

A.3.3.2.19 Support online viewing of change history.

A.3.3.2.20 Maintain edits of input data as established by the Bureau.

A.3.3.2.21 Report and resolve enrollee records that fail edits during processing.

A.3.3.2.22 Conduct periodic reconciliation of enrollee demographic, financial, eligibility, and enrollment information between the enrollee data repository, the DHS eligibility (ACCENT and/or VIP when implemented) system, MCC systems, and other sources of enrollee eligibility and enrollment information.

A.3.3.2.23 Generate and distribute enrollee Qualified Medicare Beneficiary (QMB) identification cards as required.

A.3.3.2.24 Generate an audit trail of all QMB cards produced and all online real time updates made.

A.3.3.2.25 Identify the reason for and the date of the issuance of an enrollee eligibility identification card.

A.3.3.2.26 Promptly notify the Bureau of any discrepancies or errors identified by the TCMIS, including discrepancies in the enrollee data and evidence of unsuccessful file transfers.

A.3.3.2.27 Maintain process to produce all reports for each eligibility transaction and deliver them as designated by the Bureau. Notify the Bureau of the need to resolve

edits if the Contractor is unable to resolve them.

A.3.3.2.28 Process and execute daily updates to the Eligibility and Enrollment Data Repository from external eligibility sources in sequential date order.

A.3.3.2.29 Send updates of eligibility and enrollment information in sequential date order to all interfaces as determined by the Bureau.

A.3.3.2.30 Maintain appropriate controls and audit trails to ensure that the most current enrollee data is used during each transaction processing event and system cycle.

A.3.3.2.31 Provide online access and processing to the Eligibility and Enrollment Data Repository, twenty-four (24) hours per day, seven (7) days per week. Additionally, maintenance downtime shall be scheduled according to State approved interval time units.

A.3.3.2.32 Maintain the functionality to produce mailing labels with various select-and-sort options, such as aid category, program type, date-of-birth, county, census tract, ZIP code and other selection criteria.

A.3.3.2.33 Generate and mail standard and ad hoc notices and letters to enrollees on schedule and as requested by the Bureau.

A.3.3.2.34 Maintain functionality to provide online file maintenance as directed by the Bureau.

A.3.3.2.35 Maintain functionality to support the Bureau's online Automated Voice Response System (AVRS).

A.3.3.2.36 Operate the Eligibility and Enrollment Data Repository and support online real-time and batch eligibility transaction processing twenty-four (24) hours per day, seven (7) days per week.

A.3.3.2.37 Apply batch updates to the Eligibility and Enrollment Data Repository at least daily on a schedule approved by the Bureau and report eligibility transactions which fail edits within four (4) hours. All files shall be processed in sequential date order as received.

A.3.3.2.38 Generate Eligibility and Enrollment Data Repository reports as scheduled and produce ad hoc reports within a timeframe agreed upon between the Contractor and the Bureau.

A.3.3.2.39 Assist in eligibility file reconciliation processing with MCCs, DHS, SSA or Bureau business partner.

A.3.3.2.40 Perform eligibility file maintenance processing, as needed by the Bureau.

A.3.3.2.41 Generate capitation payments to MCCs.

A.3.3.2.42 Process capitation payment adjustments.

A.3.3.2.43 Send MCCs capitation information in a HIPAA compliant format.

A.3.3.2.44 Transmit daily electronic enrollment updates to the MCCs in a HIPAA compliant format.

A.3.3.2.45 The Contractor shall complete processing of all address changes within five (5) business days of receipt of address change information. Upon implementation of recommended change requests that will develop automation of the recipient address change process (i.e., automated MCO address capabilities and automated recipient address capabilities using the National Change of Address (NCOA) database), Contractor shall complete processing of all address changes within three (3) business days. Processes include:

A.3.3.2.45.1 Obtain and file reports that are generated from the 834 file;

A.3.3.2.45.2 Stamp the report with date of receipt and log it into MCO tracking report;

A.3.3.2.45.3 Research the address to determine if the change meets the required criteria for manual update;

A.3.3.2.45.4 Update all addresses that meet the change criteria into interChange;

A.3.3.2.45.5 Perform quality control review on updates to ensure accuracy; and

A.3.3.2.45.6 Forward a copy of all addresses to associated business partners or facilities, if required, to maintain consistency in address data maintenance.

A.3.3.2.46 Operate the recipient eligibility and enrollment component of the TCMIS, including improvements/enhancements as they are implemented.

A.3.3.2.47 Ensure that all existing and new requirements of CMS, the State Medicaid Manual, and State and federal policy are implemented according to the timelines specified in the requirement.

A.3.3.2.48 Perform updates or online and/or systematic file fixes to TCMIS-specific fields and tables, as designated by the Bureau.

A.3.3.2.49 Provide assistance to the Bureau in researching enrollee and case file/database discrepancies.

A.3.3.2.50 Develop and maintain functionality to produce daily audit trail reports showing all enrollee and case data updates applied to the eligibility and case files.

A.3.3.2.51 Develop and maintain functionality to produce error reports for updates to enrollee and case data that cannot be processed.

A.3.3.2.52 Develop and maintain functionality to provide online access to all TCMIS enrollee files/database tables.

A.3.3.2.53 Maintain the benefit indicator information for enrollees to determine services to which limits apply so that claims can process correctly.

A.3.3.2.54 Maintain appropriate controls and audit trails to ensure that the most current enrollee data are used during each fee for service (FFS) claims, capitation, and encounter claims processing cycle.

A.3.3.2.55 Assist Bureau staff with research, resolution, and response to enrollee issues and problems brought to the Bureau's attention.

A.3.3.2.56 Maintain eligibility and enrollee systems documentation for Contractor and Bureau personnel, including, but not limited to, Project Work Book or approved documentation media.

A.3.3.2.57 Generate, deliver to the Bureau, and load to online electronic storage repository all enrollee reports according to schedule.

A.3.3.2.58 Generate and transmit a monthly extract file of crossover eligibility including Medicare information to the CMS designated clearinghouse for cross-over claims.

A.3.3.2.59 Purge inactive enrollee records to an archive file, based on the criteria and schedule defined and approved by the Bureau.

A.3.3.2.60 Update system and operations documentation when system changes are made, per standards documented in the TCMIS Infrastructure Documentation Sections A.5.8 and A.5.9 of this Contract.

A.3.3.2.61 Maintain eligibility and enrollment data and functionality as required to meet or exceed federal certification requirements.

A.3.3.2.62 Maintain functionality to process temporary Social Security Number (SSN) terminations, generate notices if required.

A.3.3.2.63 Support process for children turning twenty-one (21). Modify benefit category and generate appropriate notices as required by the Bureau.

A.3.3.2.64 Support process for gaining/losing Medicare. Modify benefit category and generate appropriate notices as required by the Bureau.

A.3.3.2.65 Support process for adults entering/leaving health care institutions (e.g., long term care, skilled nursing facilities, and mental health institutions). Modify benefit category and generate appropriate notices as required by the Bureau.

A.3.3.2.66 Initiate disenrollment process to support policy changes, court orders, or federal requirements, as defined by the Bureau. Generate notices as required and support data matches with other State agencies.

A.3.3.2.67 Maintain the generation of eligibility extracts to Bureau business partners that

includes, but is not limited to: DOH, DCS, other contractors, CMS, SSA, and DHS.

A.3.3.2.68 Maintain functionality to reestablish Medicaid eligibility for enrollees when they reach the end of their current eligibility, based on rules defined by the Bureau. This functionality includes, but is not limited to, interfaces with other State agencies and enrollee noticing.

A.3.3.2.69 Develop and maintain functionality to reestablish TennCare Standard eligibility for enrollees when they reach the end of their current eligibility, based on rules defined by the Bureau. This functionality includes, but is not limited to, interfaces with other State agencies and enrollee noticing.

A.3.3.2.70 Maintain the dunning process, producing notices as required by the Bureau. If premiums are not received by the time specified by the Bureau, send the appropriate dunning notice. Retain and support all information related to the dunning notices and termination notices, for example, storing date sent. Process terminations related to the dunning notice process when payments are not received by timeframe as specified by the Bureau.

A.3.3.2.71 Develop and support the process to suspend eligibility in accordance with the Bureau of TennCare Policies and Procedures and/or TennCare Rules, including, but not limited to, suspending incarcerated enrollees during the time of incarceration and assuring that all related system processes are updated with the suspense status.

A.3.3.2.72 Maintain the Mainframe processes for Medical Eligibility processing.

A.3.3.3 <u>Modification of Functionalities Requirements:</u>

The following requirements are functionalities that shall be developed and implemented by the Contractor after Bureau approval.

A.3.3.3.1 Support data extracts and online queries as needed by the Bureau.

A.3.3.3.2 Maintain and support changes to the AS400 TCMIS eligibility, inquiry and online presumptive eligibility update/add screen and batch processing.

A.3.3.3.3 Develop, maintain, and provide online inquiry access to eligibility input records received from, but not limited to, DHS, SSA, Bendex, Buy-In, MHDD, DOH, and DCS, by enrollee.

A.3.3.3.4 Support and maintain enrollee premium data including, but not limited to: adjustments to premium billing, premium payments previously processed, premium statements or notices, and premium terminations.

A.3.3.3.5 Develop and support premium termination information so that eligibility may not be reinstated for an enrollee who has been terminated for non-payment until past due payments are resolved, in accordance with Bureau policy and/or rules.

A.3.3.3.6 Develop and maintain the ability to review enrollee data and link and/or unlink multiple enrollee records (regardless of the number) and all associated tables to be recognized as a single individual, in accordance with Bureau policies and/or rules. Additionally, an audit trail of the linked records and tables shall be maintained within the system.

A.3.3.3.7 Update system and operations documentation when system changes are made, per standards documented in the documentation enhancement.

A.3.3.3.8 Require the Contractor to identify operational deficiencies and recommend solutions for improvement.

A.3.3.3.9 Support the “undeliverable” and “no response” information element for recording returned mail and notices and letters that required a response, but none was received.

A.3.3.3.10 Support the eligibility matching processes with other State agencies, vendors, and as required by the Bureau and process response files including, but not limited to, address matching and eligibility verification matching.

A.3.3.3.11 Provide translation services for multiple languages, including, but not limited to, neutral Spanish, non-Castilian Spanish, and others required by the Bureau.

A.3.3.3.12 Produce an associated report for every notice type produced.

A.3.3.3.13 Maintain functionality to provide online file maintenance as directed by the Bureau. Maintain functionality to support the TennCare web Eligibility Verification System and other contracted business partners.

A.3.3.3.14 Support data extracts and online queries for eligibility data for federal reporting, including, but not limited to: Medicaid Statistical Information System (MSIS), the Medicare Enrollment Data Base (EDB), and the Medicare Modernization Act (MMA) Part D.

A.3.3.3.15 Support suspended eligibility status for enrollees whose eligibility is suspended for a period of time as for incarcerated enrollees, causing MCC plan enrollment and capitation payments to be suspended.

A.3.3.4 Medical Eligibility Processing

Individuals who do not qualify for TennCare Medicaid may undergo an application process to determine if they qualify for Medical Eligibility (ME).

During the ME application process, DHS may approve the enrollee if s/he has a qualifying SPMI (severely and persistently mentally ill) assessment within the last year, an approved ME packet provided by the enrollee already on file, or claim/encounter data showing they have had a specific diagnosis that is on a TennCare-approved list.

During interChange editing, the ME application data is verified to ensure that all the qualifying criteria are met. If so, the individual is sent an ME packet, and interChange logic extends eligibility to give them time to return the packet.

If the enrollee does not return the packet within the specified time frame (referred to as a ”time-out” referral), a transaction is generated from the mainframe to interChange (iC), the enrollee is terminated, and a notice is generated to the applicant. If the enrollee returns the packet and is approved, the Bureau sends a transaction to DHS to indicate that the ME packet has been approved. This initiates an approval Referral record from DHS back to TennCare.

Now that adults may not be approved as TennCare Standard, not many enrollees who meet the criteria get approved under the ME category.

A.3.3.5 <u>Medical Eligibility Processing Contractor Requirements:</u>

A.3.3.5.1 Perform activities needed to process inbound Medical Eligibility (ME) packets. This includes opening, sorting, batching, scanning and/or microfilming, entering data, filing, storing, and retrieving packets. As of the Contract Start date, the number of ME Packets received for processing is only about ten (10) packets per month.

A.3.3.5.1.1 Retrieve ME Packets from the post office twice daily.

A.3.3.5.1.2 Sort ME Packets from any other mail.

A.3.3.5.1.3 Open the packets with an opening machine.

A.3.3.5.1.4 Deliver packets to the specialized ME processing clerks.

A.3.3.5.1.5 Remove packets from the envelopes.

A.3.3.5.1.6 Prepare batches for microfilming including creation of batch sheets and validating packet completeness.

A.3.3.5.1.7 Microfilm packets.

A.3.3.5.1.8 Research packets and enter the data into the system.

A.3.3.5.1.9 Forward incomplete packets to Bureau.

A.3.3.5.1.10 Prepare packets and deliver to the Bureau.

A.3.3.5.1.11 Key disposition of packets returned from the Bureau into the system.

A.3.3.5.1.12 Track undeliverable ME packets and mail again if a new address is available. If no other address is available to resend the packet, it shall then be forwarded to DHS.

A.3.3.5.2 Perform activities associated with internal ME packet operational processing. This includes researching, copying, filing, and other activities as directed by the Bureau.

A.3.3.5.2.1 File packets according to operational procedures, which include segmenting by type, date received, completeness, and other specific criteria as defined by the Bureau.

A.3.3.5.2.2 Respond to requests from the Bureau for copies of specific packets.

A.3.3.5.2.3 Perform research into the status of packets as directed by the Bureau, which may include utilizing the system, searching physical files, searching microfilm, and/or searching scanned documents.

A.3.3.5.2.4 Store, retrieve, and prepare logs for all checks received, returned, and forwarded to the Bureau.

A.3.3.5.2.5 Process ME Return to Enrollee (RTE) letters, which includes creating, validating, stuffing, sealing and applying postage.

A.3.3.5.3 The Contractor shall complete processing of all Medical Eligibility (ME) packets within a maximum of three (3) business days of receipt of the packets. The amount of time a packet awaits action by the Bureau shall be excluded from the three (3) business day turn-around requirement.

A.3.3.5.4 Upon notice of a deficiency by the Bureau, the Contractor shall propose a Corrective Action Plan (CAP) to remedy said deficiency. If the Contractor fails to complete the mutually agreed upon CAP, liquidated damages may be assessed at a rate of twenty-five percent (25%) of the current price per ME Packet for each packet that remains incomplete after the third (3rd) business day, up to a maximum of five hundred dollars ($500) per month.

A.3.3.6 Eligibility and Enrollment Inputs and Outputs

A.3.3.6.1 This table lists information about specific files that are used in TCMIS Eligibility Processes. The Contractor shall be required to maintain the Eligibility processes that utilize these files.

Eligibility Subsystem External Files

Eligibility Interface	**Entity/ Vendor**	**Input/ Output**	**Freq**	**Media**	**Info/Description**
1610 Medicaid Manual Transactions	DHS; ACCENT	Input	Daily; weekly	Cart	1610 Eligibility Updates- Eligibility - Medicaid adds & closures.
ACCENT – Reconciliation	DHS; ACCENT	Input	Monthly	EMC; CART	DHS. Eligibility. This file includes the eligibility and demographics for all current Medicaid eligible recipients.
ACCENT - Medicaid Eligibility	ACCENT	Input	Daily	Data Set	This file is the extract file from the ACCENT System containing Medicaid Applications and their disposition on DHS current files (e.g., open, close, deny).
ACCENT - TennCare Referral	DHS; ACCENT	Input	Daily	Data Set	Description: TennCare Waiver- This file provides individual demographic/eligibility information for all individuals in a TennCare family group as determined on ACCENT. It is a vehicle to establish

Eligibility Interface	Entity/ Vendor	Input/ Output	Freq	Media	Info/Description
					coverage for TennCare Standard and Medically Eligible recipients who have been processed via ACCENT.
ACCENT Waiver Pend File	DHS	Input	Daily	Data Set	This file has pended applications for the Waiver Recipients.
BENDEX	SSA	Input	Monthly	Cart	Retrieve and update Medicare information daily for effective crossover claim processing (e.g., access SSA common working file) for access to the data.
Daniels Letters-Denial Letters	Axis Direct	Output	Daily	Data Set	The *Daniels* notice is generated in the Claims functional area.
Department of Corrections (DOC)/Prisoner	DOC	Input	Weekly	EMC; Cart	Department of Corrections. Eligibility. Prisoner Eligibility- No terminations currently take place.
DHS 30/90 Day OATS	DHS	Output	On Request	Data Set	This file contains records for recipients that have been selected during the thirty (30) or ninety (90) day OATS selection process. This file is sent to DHS for OATS maintenance.
DHS Daily ineligibles	DHS	Input	Daily	Data Set	This file is used in the RID Match process. It identifies recipients whose eligibility should be terminated.
DHS Daily Individual Extract	DHS	Input	Daily	Data Set	This file has the latest status of the recipients who were selected during the OATS selection process. This file is used in the thirty (30) and ninety (90) day OATS processes.
HICN X-reference File (Health Insurance Control Number)	Medicare Carriers	Output	Monthly	Cart	Medicare Intermediaries and Carriers routinely transmit crossover claims to the TCMIS for FFS claims processing. The TCMIS shall receive FFS claims and produce and send Remittance Advice(s) in HIPAA compliant transaction formats.
Hotline Letters File (printed at OIR)	Others; OIR and EDS	Output	Quarterly; Weekly	Data Set	Letters generated from contacts made to the information line.
Immediate (Presumptive) Eligibility file	DHS	Input	Daily	Data Set	This file identifies children who have entered DCS custody.

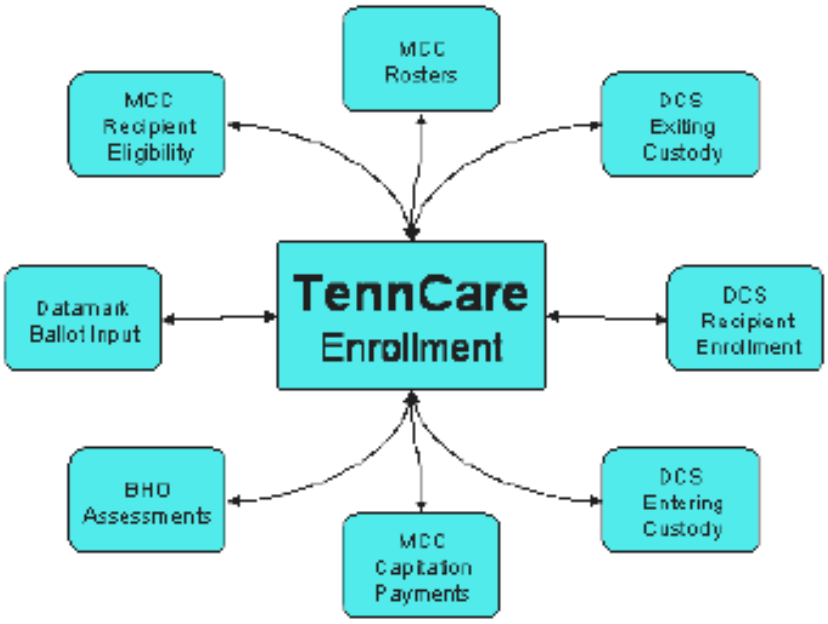
Eligibility Interface	Entity/ Vendor	Input/ Output	Freq	Media	Info/Description
Matched Input with RID Discrepancies	DHS; ACCENT		Daily	Data Set	Used for processing the Matched input with RID Discrepancy records.
Medicaid Benefits Issuance	ACCENT	Input	Daily	Data Set	The daily and monthly Medicaid Benefits Issuance file provides individual Medicaid issuance as well as demographic information. It includes information required to prepare and mail the QMB ID cards.
Medicaid Pending/Denied Individual Extract Pending file	DHS; ACCENT	Input	Daily	Data Set	This file identifies recipients that have applied for benefits through DHS. Their applications have not been approved.
Medically Eligible Approval Denial Record		Output	Daily; Weekly	Data Set	Pend Process which is detailed within the TC ACCENT Referral Process (for ACCENT/Waiver Eligibility).
Patient Liability	ACCENT	Input	Daily	Data Set	The daily, monthly and a mass change Medicaid patient liability file. The file includes begin and end dates of the patient liability amount.
Medicaid Beneficiary Issuance	DHS; ACCENT	Input	Daily; monthly	Cart	TWISS Eligibility Updates- & ID card updates. This is the actual QMB ID card process.
SDX/SSI Recon File	SSA	Input	Quarterly	Cart	The SDX Recon file will be used to reconcile and apply quarterly updates to the SSI recipient data.
SDX Treasury File	SSA	Input	Monthly	Cart	The SDX Treasury file will be used to apply monthly updates to the SSI recipient data.
SDX Update File	DHS/SSA	Input	Daily/ Weekly;	Cart	The SDX file will be used to apply daily updates to the SSI recipient data.
Sorted SSN	DHS-ACCENT	Output	Weekly	Data Set	This file contains recipients who are due for closures or applied for benefits through DHS. These recipients are included in the Medicaid extend process.
TennCare Referral Eligibility Errors	DHS-ACCENT	Input	Daily	Data Set	An ACCENT to TennCare Referral file is received daily. Syntax Edits and Eligibility edits will be performed against the file and all records that error off will be on the Referral Eligibility Error file.

Eligibility Interface	Entity/ Vendor	Input/ Output	Freq	Media	Info/Description
TennCare Referral Syntax Errors	DHS-ACCENT	Output	Daily	Data Set	The syntax edit process will be run against the DHS file as soon as it is received daily. This will allow DHS the ability to correct records and return them possibly by the end of the current day. Will also be run in nightly cycle.
TennCare Responses	DHS-ACCENT	Output	Daily	Data Set	After translation of action codes and edits are complete and a TennCare case number has been given, it is necessary to validate each record for approval or denial. A file is created with TennCare responses which includes approvals, denials and informational responses.
TennCare to ACCENT Address File	Enrollment Applications TennCare	Output	Daily	Data Set	This file is processed by Enrollment.
Termination Letters File	Axis Direct	Output	Weekly	Cart	Description: T01, T03 and T08 are the only ones done presently. The capacity for T01-T09 exists.
Vital Statistics Death File	DOH	Input	Monthly	Cart	Vital Statistics- Date of Death Notification file received from the Department of Health.
ARAD	DHS	Input	On-Request	Data Set	This file will have recipients who never went into DHS for an interview after filing an application and who will be terminated.
MHDD	MHDD	Input	Daily	Data Set	This file is received from MHDD, who determines eligibility for the Severely and Persistently Mentally Ill (SPMI) and the Seriously Emotionally Disturbed (SED) categories.
DOH Presumptive	DOH	Input	Daily	Data Set	This file is received through the iC/AS400 interface. It provides eligibility for the Presumptive eligibility category as determined by the Department of Health.
Patient Liability	DHS	Input	Daily	Data Set	This file is received daily from DHS and contains the Patient Liability begin and end dates. It also contains the Patient liability amounts.
DCS MCO	DCS	Output	Monthly	Data	This file is generated monthly to

Eligibility Interface	Entity/ Vendor	Input/ Output	Freq	Media	Info/Description
				Set	DCS and is used for Medicaid Eligibility billing.

A.3.3.6.2 Enrollment Eligibility Diagram

This Enrollment Diagram depicts specific interfaces with which Enrollment data is exchanged for TCMIS processes. The Contractor shall be expected to maintain the TCMIS Enrollment processes that utilize the data exchanged to and from these entities



A.3.3.6.3 Enrollment External Files:

This table lists information about specific files that are used in TCMIS Enrollment processes. The Contractor shall be expected to maintain and process these TCMIS Enrollment files.

Enrollment Interface Files

Enrollment Interface	Entity/ Vendor	Input/ Output	Freq	Media	Info/Description
HIPAA 820 Capitation Payment File Layout	MCC	Output	Monthly	FTP	Capitation payment detail. Sent to each MCC who receives a capitation payment.

Enrollment Interface	Entity/ Vendor	Input/ Output	Freq	Media	Info/Description
HIPAA 834 Enrollment Roster File Layout	MCC	Output	Daily	FTP	Enrollment roster sent to each MCC with enrollment information of the enrollees who are enrolled in that particular MCC.
Inbound HIPAA 834 Enrollment Roster File Layout	MCC	Input	Daily	FTP	Enrollment roster received from each MCC with enrollment information of the enrollees who are enrolled in that particular MCC.
HIPAA 271 (Unsolicited) Eligibility Response File Layout	MCC	Output	Daily	FTP	Accompanies the Enrollment roster. Includes co-pay and service limit utilization.
BALLOT ENTRY- Ballot DB	Data Mark	Input	TBD	Magnetic Tape	Process to execute the annual ballot process.
BHO Assessment File	BHO	Input	Daily	FTP	Receive and process assessment data from the BHOs.
BHO Assessment File Receipt Acknowledgment	BHO	Output	Daily	FTP	Acknowledge receipt of BHO Assessment File.
BHO ME Extract File	BHO	Output	Daily	FTP	BHO Medically Eligible Extract File.
BHO Error File	BHO	Output	Daily	FTP	Good Records and Error Records for each BHO.
BHO Return File for each BHO	BHO	Output	Daily	FTP	BHO Assessment Processing Results.
DCS Entering Custody File	DCS	Input	Daily	FTP	Children Entering Custody will be automatically assigned to MCO11.
DCS Entering Custody Ineligibles File	DCS	Output	Daily	FTP	DCS children entering custody who are ineligible.
DCS Entering Custody No Match File	DCS	Output	Daily	FTP	DCS children entering custody who are not matched in the system.
DCS Entering File Receipt Acknowledgment (This file is produced but not sent to DCS)	DCS	Output	Daily	FTP	Acknowledge receipt of DCS Entering File.
DCS Exiting	DCS	Input	Daily	FTP	Children Exiting Custody will be moved

Enrollment Interface	Entity/ Vendor	Input/ Output	Freq	Media	Info/Description
Custody File					into MCO 004.
DCS Exiting Custody Ineligibles Files	DCS	Output	Daily	FTP	DCS children exiting custody who are ineligible.
DCS Exiting Custody No Match File	DCS	Output	Daily	FTP	DCS children exiting custody who are not matched in the system.
DCS Exiting Custody Wrong SSN File	DCS	Output	Daily	FTP	DCS children exiting custody whose SSN is not matched in the system.
DCS Exiting Custody No Name File	DCS	Output	Daily	FTP	DCS children exiting custody whose name is not found in the system.
DCS Exiting Custody No DOB File	DCS	Output	Daily	FTP	DCS children exiting custody whose Date of Birth is not found in the system.
DCS Exiting File Receipt Acknowledgment (This file is produced but not sent to DCS)	DCS	Output	Daily	FTP	Acknowledge receipt of DCS Exiting File.
DCS Recipients MCO11 File	MCO	Output	Daily	FTP	Contains entering or exiting DCS recipients who are enrolled in MCO11.
DCS Recipients BHO Files	BHO	Output	Daily	FTP	Contains entering or exiting DCS recipients who are enrolled in each BHO.

A.3.3.7 Eligibility and Enrollment Bureau Responsibilities:

A.3.3.7.1 Coordinate and arrange for the receipt of all eligibility data and information by the Contractor.

A.3.3.7.2 Arrange for the Contractor to have inquiry access to ACCENT, TN KIDS (system maintained by DCS that is used to derive the DCS files), and other eligibility sources to obtain enrollee data.

A.3.3.7.3 Assist in the correction of errors and discrepancies resulting from the eligibility update process between the eligibility information interface sources and the TCMIS.

A.3.3.7.4 Monitor daily activities and processing results.

A.3.4 Correspondence, Letters and Notices

The Bureau generates and mails a wide array of official notices, letters and correspondence to applicants, enrollees, and business partners. The correspondence, letters, and notices relate to eligibility application (approval or denial), enrollment, premium billing, dunning notices, complaints, grievances and appeals, information verification letters, legal matters, benefit levels, EPSDT services, TPL questionnaires, and member service correspondence. Nearly all TCMIS correspondences are printed at the State's Data Center within the Office for Information Resources (OIR) and then are delivered to the TCMIS Facilities Manager for distribution. Occasionally, when notices shall be mailed to the entire eligible TennCare population, external vendors may be used by the Contractor (with Bureau approval), to assist with the printing and preparation for these mailings because of extreme volumes and time constraints.

Most correspondence and notice items have stringent distribution deadlines.

Other notices and letters are generated from another network or PC files not integrated with the interChange TCMIS. Member Services and the TennCare Solutions Unit (TSU) produce and distribute over forty (40) letter types from the ProLaw system or from individual PC files.

A.3.4.1 Correspondence, Letters and Notices Management

The interChange TCMIS supports the management of correspondence, letters, and notices. The correspondences are stored in the image storage area and are linked to their intended receiver for tracking of communications.

A.3.4.2 Correspondence, Letters and Notices Contractor Requirements:

A.3.4.2.1 The Contractor shall support the management of correspondence, letters, and notices, including maintaining the image storage area and linkage to recipient data for future tracking of communications. The correspondence process shall be supported by the Siebel Correspondence screens.

A.3.4.2.2 Support single letter selection and mailing from object letters in the repository or customization of letters using templates for letter type.

A.3.4.2.3 Support history retention of correspondence including date produced, enrollee, business partner, or provider address where mailed.

A.3.4.2.4 Support process to produce an unlimited number of letters with version control capabilities.

A.3.4.2.5 Provide translation services for multiple languages, including, but not limited to, Neutral Spanish, non-Castilian Spanish, and others as required by the Bureau.

A.3.4.2.6 Maintain association between letter history to an enrollee, provider, or business partner record with access to all correspondence from the enrollee, provider or business partner record.

A.3.4.2.7 Associate correspondence to a head of household and/or to all enrollee records in the household or as designated by the Bureau.

A.3.4.2.8 Support sending correspondence to multiple mailing address selection for an enrollee based on varying sources of data. Retain multiple addresses in enrollee history.

A.3.4.2.9 Provide access to correspondence history by multiple keys (e.g., name, case or enrollee ID, SSN, Tax ID and other search criteria).

A.3.4.2.10 Support digital image reproduction, including all address elements, index numbers, date of letter, date printed and precise image.

A.3.4.2.11 Support user security for approved letter generation (e.g., only specified end-users approved to generate specific correspondence).

A.3.4.2.12 Provide the functionality to auto-generate letters and notices for: eligibility additions, updates, status changes, certifications, complaints, grievances, appeals and terminations.

A.3.4.2.13 Provide functionality to suspend termination letters when a date of death is recorded.

A.3.4.2.14 Support the mass mailing selection facility for one (1) time noticing with selection criteria by provider, enrollee, and Managed Care Contractor and eligibility category within each.

A.3.4.2.15 Develop the ability and maintain the functionality to support the ability to image, associate, and identify attachments to letters and correspondence, and attach scanned/imaged documents, including, but not limited to, manually generated correspondence.

A.3.4.2.16 Support the “undeliverable” and “no response” process to record returned mail information for notices and letters that had required a response, but for which none was received.

A.3.4.2.17 Maintain and operate the interChange Correspondence, Letters and Notices Management application.

A.3.4.2.18 Produce correspondence, letters and notices print files with detail reports regarding the mailing, as needed by the Bureau.

A.3.4.2.19 Produce an associated online and hard copy control and activity report for each type of notice produced, as required by the Bureau.

A.3.4.2.20 Using the most cost effective postage rate according to TennCare policy, prepare and mail outgoing correspondence, letters, and notices, regardless of volume or size.

A.3.4.2.21 Generate correspondence, letters, and notices on a schedule defined by the Bureau and coordinating electronic files in format as defined by the Bureau.

A.3.4.2.22 Generate and deliver documentation requested in an ad hoc request for correspondence, letters and notices within twenty-four (24) hours of the request.

A.3.4.2.23 Mail, at the most cost effective postage rate, outgoing correspondence, notices, and letters within twenty-four (24) hours of receipt of special printed materials from the Bureau or within a Bureau specified timeline.

A.3.4.2.24 Develop and produce any new enrollee notifications as required by the Bureau, and provide detailed reports containing enrollee data needed for notice review procedures.

A.3.4.2.25 Maintain annual counts of enrollee notices by notice type.

A.3.4.2.26 Capture online entered “returned undeliverable mail” (returned mail) information, using changed address information on returned mail to update address files and reprocess outgoing correspondence.

A.3.4.2.27 The Contractor shall process returned mail within ten (10) business days of receipt of the returned undeliverable. This process includes, but is not limited to:

A.3.4.2.27.1 Retrieve returned mail from post office;

A.3.4.2.27.2 Sort by response type;

A.3.4.2.27.3 Prepare and copy undeliverable envelope front;

A.3.4.2.27.4 Batch and scan copies of the returned mail;

A.3.4.2.27.5 Index returned mail;

A.3.4.2.27.6 Forward returned mail with a forwarding address to the appropriate department for further processing, and maintain tracking report;

A.3.4.2.27.7 Open and evaluate contents:

a. update address in iC when applicable

b. re-mail to new address

c. forward new addresses to appropriate business partner;

A.3.4.2.27.8 Perform quality control on addresses updated in iC to ensure accuracy;

A.3.4.2.27.9 Update tracking inventory and generate weekly status report; and

A.3.4.2.27.10 File and store returned mail.

A.3.4.2.28 Whenever external printing/mailing services are utilized because of extreme volumes or time constraints, the Contractor shall undertake enhanced quality review functions.

A.3.4.2.29 Contractor shall be responsible for managing printing/mailing services whenever an external vendor is used, ensuring that the printing specifications, quality and schedule meet the Bureau’s requirements.

A.3.4.2.30 Print correspondence, letters and notices and deliver to the Contractor within twenty-four (24) hours of receipt of print files, so that they can review and prepare for mailing.

A.3.4.2.31 Contractor shall ensure that correspondence, letters, and notices printed at OIR are promptly reviewed for quality assurance (Q/A), processed, and prepared for mailing, within twenty-four (24) hours of receiving the printed documents.

A.3.4.3 Modification of Functionalities Requirements:

The following requirements are functionalities that shall be developed and implemented by the Contractor after Bureau approval.

A.3.4.3.1 Develop the ability to provide and support the functionality to re-send correspondence by approved end-user promptly, and provide online viewing of initiating operator audit trail.

A.3.4.3.2 Generate TPL questionnaires (to be printed at OIR), and mail, either by the Contractor, or the Contractor's mail vendor.

A.3.4.3.3 Develop and produce any new enrollee notifications as required by the Bureau, and develop and provide associated detailed reports to assist in the validation process.

A.3.4.3.4 Develop and produce a summary report that shows periodic (weekly/monthly/annual) accumulated totals by notice type.

A.3.4.4 Correspondence, Letters and Notices Bureau Responsibilities:

A.3.4.4.1 Authorize and approve end-user security and access capabilities of data related to letters and notices.

A.3.4.4.2 Review and approve template formats and standard notice content.

A.3.5 Complaints/Grievances/Appeals

Complaints, Grievances, and Appeals are submitted by an enrollee when s/he disagrees with Bureau actions or decisions. Appeals include all complaints and grievances filed by an enrollee whether or not they are escalated to a formal appeal. There are two (2) major classifications of appeals, Administrative and Medical.

A.3.5.1 Administrative Appeals Unit Overview

Administrative Appeals are actions taken by the Bureau or a MCC. These may include actions for denial of coverage or termination of eligibility with disenrollment from a TennCare MCC plan. These are handled by the Administrative Appeals Unit (AAU).

The types of appeals handled by the AAU are referred to as "redeterminations", and "new enrollee denied applications".

”Redetermination” involves enrollees who have been enrolled in TennCare, but have had a re-evaluation of their demographic information, address, income, marital status, or insurance status. The Bureau selects these individuals for review, and forwards their information to DHS. DHS conducts a review and either determines that the individual’s eligibility status is appropriate, or that changes should be made and that the individual should not be eligible. DHS presents their decision to the TennCare recipient, which may affect the recipient to initiate an appeal.

A ”new enrollee denied application” originates when an applicant who had applied for TennCare through DHS and was denied, files an appeal.

A.3.5.2 Medical Appeals/TSU Overview

Medical appeals are submitted by an enrollee and are for medical services or quality of care medical issues. These are handled by the TennCare Solutions Unit (TSU).

The TennCare Solutions Unit (TSU) processes information based upon a recipient’s right to appeal adverse actions affecting his/her covered services and benefits. If the complaint or grievance is not resolved to the enrollee’s satisfaction, the enrollee is advised of his/her right to appeal the decision and a formal appeal handling process is implemented. The enrollee complaint and grievance documentation and review process includes referring the grievance or complaint within each of the business units for resolution and/or referral to the Managed Care Contractor or provider. If the enrollee is not satisfied with the outcome, the complaint or grievance is escalated to a formal appeal and the case is referred to the TennCare Solutions Unit (TSU) for resolution.

For TSU appeals, a federal court order, the *Grier Revised Consent Decree (Modified)* of *Grier v. Goetz*, governs specific timeframes required in processing an appeal in a timely fashion. Timely is defined as ninety (90) days for a non-expedited appeal, thirty (30) days for an expedited appeal, and forty-five (45) days for a pharmacy appeal. Medical appeals include:

Medical Services

Behavioral Health Organization (BHO)

Department of Children’s Services (DCS)

Pharmacy

Reimbursement and Billing

Mental Retardation and Developmental Disabilities (MR/DD)

Managed Care Contractor Change Request (MCC Change Request)

Information is received through several methods: e-mail, fax, phone, in person, and/or by mail. Formal letters and notices are generated to enrollees advising of appeal rights throughout the process. Assistance with filing an appeal is offered.

Enrollees may appeal any action or decision of the Bureau or a Managed Care Contractor, directly to the Bureau. If the appeal is not resolved either by the TennCare Solutions Unit, or the Member Services units through informal or formal decisions, the enrollee may request a formal hearing before an Administrative Law Judge (ALJ). Appeals escalated to the hearing level are referred to the Bureau Legal Solutions Unit (LSU) for handling. Types of appeals include:

Medical issues;

Pharmacy issues;

Department of Children's Services issues;

Division of Mental Retardation Services issues;

Department of Mental Health and Developmental Disabilities issues; and

Reimbursement issues.

The Legal Solutions Unit (LSU) within the Bureau is responsible for preparing appeal cases for formal hearings. A separate system not integrated with iC, (ProLaw), is used for TennCare's Complaints, Grievances, and Appeals Tracking processes.

Internal Audits are performed to make sure that due process is followed and the Bureau is in compliance with complaints, grievances and appeals; and to assure they are resolved within the time lines prescribed and within the policy and procedure of the Bureau.

The Office of General Counsel (OGC) within the Bureau is responsible for preparing cases for hearing for the following types of cases:

TPL subrogation;

Estate recovery;

Long Term Care medical recipient appeals (PAE); and

Home and Community-Based Services (HCBS) Waiver and the Program of All-Inclusive Care for the Elderly (PACE) service denial and disenrollment appeals.

A.3.5.3 Complaints/Grievances/Appeals Contractor Requirements:

A.3.5.3.1 Maintain the functionality to allow authorized users to access and update MCC enrollment information, demographic data, and other eligibility data as directed by the Bureau, when the Appeals Unit receives this request.

A.3.5.3.2 Allow access to all claims/encounter claims history that is needed by authorized users regarding appeals processes.

A.3.5.3.3 Generate management reports for administrative appeals to the Appeals Resolution Tracking System (ARTS) according to schedule as defined by the Bureau.

A.3.5.3.4 Maintain imaging equipment to allow appeal documentation to be scanned into the system at point of receipt, as required by the Bureau.

A.3.5.3.5 Develop the methodology to store imaged documents and then allow them to be accessed by Siebel component.

A.3.5.3.6 Maintain the functionality to track appeals twenty-four (24) hours per day, seven (7) days per week and allow authorized users to access the appeal or query on the status of an appeal.

A.3.5.3.7 Assign a Bureau defined "type" of complaint, grievance or appeal (e.g., Reimbursement, Medical Necessity, and Pharmacy).

A.3.5.3.8 Support recording of administrative complaints, grievances and appeals. Report monthly, the administrative appeals that have a “pending” status. Generate reports on decisions for administrative complaints, grievances, and appeals.

A.3.5.3.9 Maintain the capability in interChange to produce, distribute, store and reproduce Bureau defined letters and notices associated to a case, which shall meet “legal” document standards in the event they are used in hearings.

A.3.5.3.10 When specific types of appeals cases exist, maintain open eligibility during the eligibility termination process until the case is closed, or as otherwise defined by the Bureau.

A.3.5.3.11 Maintain TCMIS files, systems, and interfaces, which support the administrative legal Complaints, Grievances and Appeals Tracking System.

A.3.5.3.12 Generate and route Complaints, Grievances and Appeals "Alert" report to Bureau defined destinations, by 8:30 a.m., Central Time, on business days.

A.3.5.3.13 Contractor shall make changes to procedures based on the Bureau's guidance, or make recommendations where appropriate, to modify policy in order to reduce reconsideration claims.

A.3.5.3.14 Provide appeal rights on all reprocessed claims denied.

A.3.5.3.15 Update Operational procedures manuals and System documentation where appropriate.

A.3.5.4 Modification of Functionalities Requirements:

The following requirements are functionalities that shall be developed and implemented by the Contractor after Bureau approval.

A.3.5.4.1 Develop functionality to enable authorized users to access Pharmacy lock-in data.

A.3.5.4.2 Develop and maintain functionality for benefit limit overrides during and after appeals.

A.3.5.4.3 Maintain online access to modify benefit limits packages for authorized users as directed by the Bureau. Provide and maintain a benefit limits audit window with online access.

A.3.5.4.4 Develop and maintain functionality to update and display appeals stored within the ProLaw system.

A.3.5.5 Complaints/Grievances/Appeals Bureau Responsibilities:

A.3.5.5.1 Enter online “case” information and maintain case records.

A.3.5.5.2 Act as liaison between the Contractor and external agencies and entities.

A.3.5.5.3 Review “alert” reports and take appropriate action to resolve appeals nearing deadlines.

A.3.5.5.4 Enter online “Appeal” information and maintain case records.

A.3.6 Benefit Packages

A.3.6.1 Benefit Packages Overview

As of the Contract Start date, there are nine (9) groups of Benefit Plans with indicators assigned to each: “A” through “I”. New Benefit Plan Indicators of “F” through “I” only became effective January 1, 2006.

The tables depicted in this Section detail the services provided for each of the Benefit Plan Indicators. As of the Contract Start date, the benefit year is the State of Tennessee Fiscal Year, which is July 1 through June 30.

The following table depicts Benefit Plan Indicator A: For TennCare Standard and Medicaid recipients under age twenty-one (21) who are not in an Illegal Alien or Dual Eligible (Medicare with Medicaid or Medicare with optional Medicaid) category:

Benefit Package Coverage Tables

Benefit Plan A	Coverage
Prescription Medication	As medically necessary
Inpatient Hospital Days	As medically necessary
Inpatient Physician Visits (Days)	As medically necessary
Physician Visits	As medically necessary
Outpatient Hospital Visits	As medically necessary
Laboratory and Radiology Procedures	As medically necessary
Dental Services	Covered
Methadone Clinic Services	Covered
Inpatient and Outpatient Substance Abuse Services	Covered as medically necessary

The following table depicts Benefit Plan Indicator B: For non-institutionalized TennCare Medicaid recipients aged twenty-one (21) and older in a mandatory or optional Medicaid category:

Benefit Plan B	Coverage
Prescription Medication	Five (5) prescriptions/month, maximum of two (2) brand name
Inpatient Hospital Days	Twenty (20) days per benefit year
Inpatient Physician Visits (Days)	Twenty (20) days per benefit year
Physician Visits	Twelve (12) visits per benefit year
Outpatient Hospital Visits	Eight (8) visits per benefit year
Laboratory and Radiology Procedures	Ten (10) occasions per benefit year
Dental Services	Not Covered
Methadone Clinic Services	Not Covered
Inpatient and Outpatient Substance Abuse Services	Thirty thousand dollars ($30,000) Substance Abuse Treatment services lifetime limit and ten (10) day Detox lifetime limit

The following table depicts Benefit Plan Indicator C: For TennCare Standard recipients aged twenty-one (21) and older:

Benefit Plan C	Coverage

Benefit Plan C	Coverage
Prescription Medication	Not Covered
Inpatient Hospital Days	Twenty (20) days per benefit year
Inpatient Physician Visits (Days)	Twenty (20) days per benefit year
Physician Visits	Twelve (12) visits per benefit year
Outpatient Hospital Visits	Eight (8) visits per benefit year
Laboratory and Radiology Procedures	Ten (10) occasions per benefit year
Dental Services	Not Covered
Methadone Clinic Services	Not Covered
Inpatient and Outpatient Substance Abuse Services	Thirty thousand dollars ($30,000) Substance Abuse Treatment services lifetime limit and ten (10) day Detox lifetime limit

The following table depicts Benefit Plan Indicator D: For non-institutionalized non-pregnant TennCare Medicaid recipients aged twenty-one (21) and older in an optional Medicaid category:

Benefit Plan D	Coverage
Prescription Medication	Five (5) prescriptions/month, maximum of two (2) brand name
Inpatient Hospital Days	Twenty (20) days per benefit year
Inpatient Physician Visits (Days)	Twenty (20) days per benefit year
Physician Visits	Twelve (12) visits per benefit year
Outpatient Hospital Visits	Eight (8) visits per benefit year
Laboratory and Radiology Procedures	Ten (10) occasions per benefit year
Dental Services	Not Covered

Methadone Clinic Services	Not Covered
Inpatient and Outpatient Substance Abuse Services	Thirty thousand dollars ($30,000) Substance Abuse Treatment services lifetime limit and ten (10) day Detox lifetime limit

The following table depicts Benefit Plan Indicator E: For institutionalized TennCare Medicaid recipients aged twenty-one (21) and older in a mandatory or optional Medicaid category:

Benefit Plan E	Coverage
Prescription Medication	As medically necessary
Inpatient Hospital Days	As medically necessary
Inpatient Physician Visits (Days)	As medically necessary
Physician Visits	As medically necessary
Outpatient Hospital Visits	As medically necessary
Laboratory and Radiology Procedures	As medically necessary
Dental Services	Not Covered
Methadone Clinic Services	Not Covered
Inpatient and Outpatient Substance Abuse Services	As medically necessary

The following table depicts Benefit Plan Indicator F: For non-institutionalized TennCare recipients aged twenty-one (21) and older in a Dual Eligible category (Medicare with Medicaid or Medicare with optional Medicaid):

Benefit Plan F	Coverage
Prescription Medication	Not Covered

Benefit Plan F	Coverage
Inpatient Hospital Days	Twenty (20) days per benefit year
Inpatient Physician Visits (Days)	Twenty (20) days per benefit year
Physician Visits	Twelve (12) visits per benefit year
Outpatient Hospital Visits	Eight (8) visits per benefit year
Laboratory and Radiology Procedures	Ten (10) occasions per benefit year
Dental Services	Not Covered
Methadone Clinic Services	Not Covered
Inpatient and Outpatient Substance Abuse Services	Thirty thousand dollars ($30,000) Substance Abuse Treatment services lifetime limit and ten (10) day Detox lifetime limit

The following table depicts Benefit Plan Indicator G: For institutionalized TennCare recipients aged twenty-one (21) and older in a Dual Eligible category (Medicare with Medicaid or Medicare with optional Medicaid):

Benefit Plan G	Coverage
Prescription Medication	Not Covered
Inpatient Hospital Days	As medically necessary
Inpatient Physician Visits (Days)	As medically necessary
Physician Visits	As medically necessary
Outpatient Hospital Visits	As medically necessary
Laboratory and Radiology Procedures	As medically necessary
Dental Services	Not Covered
Methadone Clinic Services	Not Covered

Benefit Plan G	Coverage
Inpatient and Outpatient Substance Abuse Services	Thirty thousand dollars ($30,000) Substance Abuse Treatment services lifetime limit and ten (10) day Detox lifetime limit

The following table depicts Benefit Plan Indicator H: For TennCare recipients under age twenty-one (21) in a Dual Eligible category (Medicare with Medicaid or Medicare with optional Medicaid):

Benefit Plan H	Coverage
Prescription Medication	Wrap-around coverage
Inpatient Hospital Days	As medically necessary
Inpatient Physician Visits (Days)	As medically necessary
Physician Visits	As medically necessary
Outpatient Hospital Visits	As medically necessary
Laboratory and Radiology Procedures	As medically necessary
Dental Services	Covered
Methadone Clinic Services	Covered
Inpatient and Outpatient Substance Abuse Services	Thirty thousand dollars ($30,000) Substance Abuse Treatment services lifetime limit and ten (10) day Detox lifetime limit

The following table depicts Benefit Plan Indicator I: For TennCare recipients of any age (children under age twenty-one (21) and adults aged twenty-one (21) and older) in an Illegal Alien category:

Benefit Plan I	Coverage

Benefit Plan I	Coverage
Prescription Medication	Not Covered
Inpatient Hospital Days	Emergency Only
Inpatient Physician Visits (Days)	Emergency Only
Physician Visits	Emergency Only
Outpatient Hospital Visits	Emergency Only
Laboratory and Radiology Procedures	Emergency Only
Dental Services	Not Covered
Methadone Clinic Services	Not Covered
Inpatient and Outpatient Substance Abuse Services	Not Covered

A.3.6.2 TCMIS Benefit Packages Function

The interChange Benefit Package function facilitates the storage and processing of detailed information about the aid category and the scope of services covered under each Benefit Plan. This structure allows eligible recipients who meet the qualification requirements to have one (1) or more Benefit Package(s).

Dependent upon the qualified category of eligibility, enrollees receive certain benefits. The various Benefit Packages information in the TCMIS is stored and maintained in database tables.

Services for most of Tennessee's eligible populations are provided through a network of Managed Care Contractors (MCC). The Bureau contracts with Managed Care Organizations (MCOs), Behavioral Health Organizations (BHOs), an Administrative Service Organization (ASO), a Pharmacy Benefits Manager (PBM), and a Dental Benefits Manager (DBM) to deliver services through networks of providers. TennCare enrollees, except for Qualified Medicare Beneficiaries (QMBs) and Special Low-Income Medicare Beneficiaries (SLMBs), are enrolled in an MCO. which provides both medical and behavioral health services. The ASO serves DCS-eligible children, Supplemental Security Income (SSI) children, and out-of-state enrollees. The ASO has separate MCO and BHO components. It also serves enrollees, statewide, in the event that an MCO is not available or has maximized their enrollment limitation. Special individuals eligible for mental health services are enrolled with only a BHO, (and no MCO).

Enrollment is based on the location of the enrollee, the plan affiliation of currently enrolled family members, the plan's availability to accept enrollment within the geographic location of the enrollee, the plan elected by the enrollee, and the eligibility category or categories(s) of the enrollee. Enrollees may elect a plan of choice. However, if the enrollee made a selection and the MCO is not available or is invalid, based on the enrollee's eligibility category or location, the individual(s) is randomly assigned using established algorithms. New SSI enrollees, unless they

are children under nineteen (19) years of age, are randomly assigned. The BHO enrollment is synchronized with the MCO who is selected or assigned, unless the MCO assigned was one (1) who provides both medical and mental health services. The random assignment process occurs weekly. Enrollees are notified of their MCO assignment and have ninety (90) days to change their MCO selection.

A.3.6.3 Benefit Packages Contractor Requirements:

A.3.6.3.1 According to TennCare Policies and Procedures and/or rules, support and maintain covered services relating to benefit packages, drug formulary, rate setting and modeling.

A.3.6.3.2 Maintain rates and price data including Capitation rates, Professional service Fee-for-Service rates (e.g. Usual and Customary and Reasonable Rates, prevailing by region and specialty, and maximum fees), Drug Pricing, Hospital In and Out Patient Facility rates (all rate setting methodologies), nursing home per diems (Nursing Home (NH), Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF) and Intermediate Care Facility/Mentally Retarded (ICF/MR)), and premium rates.

A.3.6.3.3 Support TCMIS functionality to maintain multiple benefit package data and related enrollee association. This includes allowing an eligible enrollee to be assigned one (1) or more benefit packages, based on eligibility categories, location, age and gender variables and family affiliations. This data will be used when editing enrollee claims and encounters against covered benefits, premium rate selection or calculation.

A.3.6.3.4 Maintain the administration of various benefit products offered by the Bureau including Managed Care Contractors/Behavioral Health Organizations, Administrative Services Only Contracts, carve-out programs such as Dental and Pharmacy providers and Fee-for-service (all claims and service types).

A.3.6.3.5 Maintain the assignment of benefit packages of covered services by category of service.

A.3.6.3.6 Develop and maintain capabilities for creating, monitoring, and updating benefit packages, including “carve-out services” and override capabilities, within the existing TCMIS.

A.3.6.3.7 Maintain the process for pharmacy carve-out services by PBM. Also maintain the process for dental carve-out services by DBM.

A.3.6.3.8 Maintain all current capabilities for creating, monitoring, and updating drug formularies within the existing TCMIS.

A.3.6.3.9 Develop and maintain the capability to create, monitor, and update multiple benefit packages by effective date, including associated benefit plan premium amounts. Each benefit package shall continue to be uniquely identifiable within the system.

A.3.6.3.10 Develop and maintain the assignment process that assigns an individual or category of individuals to benefit packages, according to a hierarchy of the Bureau Policies and/or rules.

A.3.6.3.11 Develop and maintain edits and historical information for lifetime maximum amounts on an individual member accumulation basis.

A.3.6.3.12 Develop and maintain edits and historical information for prior authorization limits on an individual member accumulation basis.

A.3.6.3.13 Develop and maintain edits and historical information for benefit (frequency) limits by procedure code, diagnosis code, associated effective dates and by benefit plan.

A.3.6.3.14 Develop and maintain edits and historical information for the accumulation of out-of-pocket amounts, co-payments and deductibles, on an individual or family aggregated basis, and support online access to this information.

A.3.6.3.15 Develop and maintain edits and historical information for BHO encounters for service limitations (the limit, as of the Contract Start date, is thirty thousand dollars ($30,000) lifetime limit or forty-five (45) visits for substance abuse), to eliminate potential duplicate payments.

A.3.6.3.16 Develop and maintain edits and historical information for fee-for-service claims and encounter claims to accumulate service limits using parameters established for each benefit plan.

A.3.6.3.17 Maintain the functionality to track overrides for benefit limits during claim adjudication with appropriate audit trail.

A.3.6.3.18 Maintain functionality to alert enrollee's MCC when the maximum enrollee/family co-payments, deductibles, coinsurance amounts or services limits are met, as directed by the Bureau.

A.3.6.3.19 Maintain rate tables for benefit packages that may assign different rates for different categories of enrollees, including sex, age, income, and family composition.

A.3.6.3.20 Maintain the assignment for provider types ranges, covered procedure codes, and payment arrangements to specified waiver services and TennCare programs.

A.3.6.3.21 Produce reports relative to covered benefits and denied or non-covered services.

A.3.6.3.22 Develop and maintain a rate modeling process by eligibility category using a variety of rates.

A.3.6.3.23 Maintain all current reimbursement methodologies and rates, as well as offer the flexibility to accommodate new methods. Reimbursement methodologies

include:

A.3.6.3.23.1 Usual, Customary and Reasonable (UCR) rates;

A.3.6.3.23.2 Prevailing rates by region and specialty;

A.3.6.3.23.3 Maximum fee schedules;

A.3.6.3.23.4 Percent of charges;

A.3.6.3.23.5 Percentage of fee-for-service rates;

A.3.6.3.23.6 Per diem;

A.3.6.3.23.7 Diagnosis Related Groups (DRG) for hospital admissions (not currently used);

A.3.6.3.23.8 Cost-based percentage based upon cost settlement and audit results;

A.3.6.3.23.9 Resource based relative value scale (RBRVS) (not currently used);

A.3.6.3.23.10 Percentage of RBRVS (not currently used);

A.3.6.3.23.11 Capitation rates;

A.3.6.3.23.12 Contracted amount;

A.3.6.3.23.13 Average Wholesale Price (AWP);

A.3.6.3.23.14 Minimum established percents for drug claims;

A.3.6.3.23.15 Disproportionate share payments;

A.3.6.3.23.16 Administrative or incentive payments;

A.3.6.3.23.17 Drug Rebates; and

A.3.6.3.23.18 Premium Collections and Reimbursements.

A.3.6.3.24 Maintain fee schedules and rate setting structures.

A.3.6.3.25 Maintain online viewing of provider and/or MCC rate histories.

A.3.6.3.26 Generate reports of rate maintenance changes as defined by and for validation by the Bureau.

A.3.6.3.27 Process and maintain rate updates generated from internal Bureau sources or through automated processes.

A.3.6.3.28 Maintain at least sixty (60) months of historical rates and associated effective dates and make available for online viewing.

A.3.6.3.29 Maintain individual provider and/or MCC rate changes or mass changes to rate tables and fee schedules with retroactive effective dates.

A.3.6.3.30 Maintain system edits and reference files to ensure processing occurs within the covered scope of service and the benefit plans.

A.3.6.3.31 Generate, produce, and distribute benefit plan utilization reports, as needed by

the Bureau.

A.3.6.3.32 Generate, produce and distribute rate-modeling reports, as needed by the Bureau.

A.3.6.3.33 Develop and maintain functionality to identify enrollees and providers participating in various managed care programs.

A.3.6.3.34 Capture and maintain all data elements necessary to support the generation of health plan rosters, managed care payment processing, and other managed care functions.

A.3.6.3.35 Support ANSI X12N 834, Benefit Enrollment and Maintenance, and 820, Premium Payment transactions from health plans and provider networks for updating interChange eligibility files with health plan enrollment and primary care case manager assignments.

A.3.6.3.36 Perform all automated processes related to enrollee participation in managed care, including, but not limited to, auto-assignment, roster generation, and data updates.

A.3.6.3.37 Update system and operations documentation when system changes are made.

A.3.6.4 Benefit Packages Bureau Responsibilities:

A.3.6.4.1 Notify the Contractor of any changes to benefit plans and the scope of services covered under each benefit package.

A.3.6.4.2 Notify the Contractor of Policy and Procedure and/or rule updates and changes.

A.3.6.4.3 Notify the Contractor of rate and fee schedule updates and changes.

A.3.7 EPSDT

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federally mandated program issued to provide health care services to children from birth to age twenty (20). The TennCare program extends the EPSDT benefit to also include the uninsured/uninsurable under age twenty-one (21) population. Tennessee's EPSDT program is referred to as "TENNderCARE", and is a full program of check ups and health care services for children already on TennCare. These services make sure babies, children, teens, and young adults receive the health care they need.

The EPSDT services include health screenings and treatment services to promote early detection of potentially chronic and disabling health conditions. Children enrolled in the EPSDT program are allowed to receive services that are not available to the general TennCare population, when the services are medically necessary to treat identified conditions.

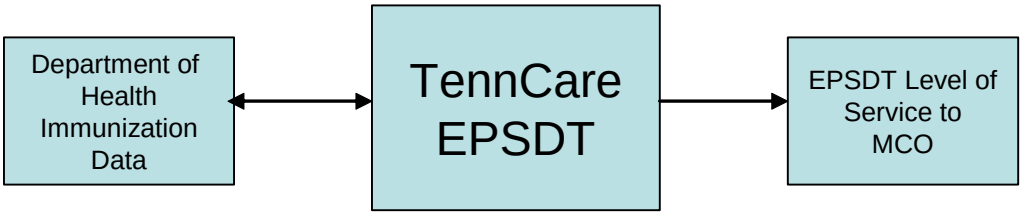
The interChange EPSDT function serves as the Bureau's mechanism to identify and track EPSDT services and to generate notification letters to eligible individuals. The functions are supported within interChange by a series of windows and reports developed to accommodate the

Bureau's needs. Immunization data, originating from the Department of Health (DOH), is stored and is accessible to be processed and viewed for an EPSDT recipient. Using claims history from MCO encounter data, several reports are created which are used to monitor the EPSDT recipient screenings, report provider costs for screenings, monitor scheduled appointments and identify providers eligible to perform EPSDT services.

The notification process identifies recipients who are new to the EPSDT program and informs them of available EPSDT services. It also notifies those recipients who are due for EPSDT screenings and those recipients who have missed an EPSDT screening. Additional EPSDT information (e.g., windows, reports and notices) can be found in the PWB within the EPSDT functional area.

The Contractor shall be required to maintain EPSDT processes in which specific EPSDT interfaces are used.

This EPSDT External Interface Diagram depicts specific interfaces that are used in TCMIS EPSDT processes. The Contractor is required to maintain these processes.



A.3.7.1 <u>EPSDT Contractor Requirements:</u>

A.3.7.1.1 Maintain functionality to identify all eligible children for EPSDT medical, dental, and/or vision services.

A.3.7.1.2 Support functionality to track each child who has received EPSDT medical, dental, and/or vision screening and/or support services, including, but not limited to, immunization and lead screening.

A.3.7.1.3 Maintain functionality to track services for children with abnormalities found during EPSDT screenings.

A.3.7.1.4 Support functionality to capture EPSDT medical, dental, and vision screenings from various sources.

A.3.7.1.5 Maintain functionality to identify and capture claims data containing EPSDT services.

A.3.7.1.6 Using interChange windows, maintain functionality to display and update EPSDT related data, including, but not limited to: claims history, immunization data, schedules, notes, letters, provider, treatment, and referral information.

A.3.7.1.7 Support and maintain the process to receive and process immunization data from

DOH to maintain EPSDT data on a weekly schedule, or as required by the Bureau.

A.3.7.1.8 Support and maintain the process to extract and generate EPSDT data and produce files for each MCO on a monthly schedule, or as required by the Bureau.

A.3.7.1.9 Support and maintain the functionality to produce EPSDT related reports which are used to monitor EPSDT activities, including costs, screenings, and provider data.

A.3.7.1.10 Support and maintain the process to extract and generate EPSDT immunization data and produce files for DOH on a weekly schedule, or as required by the Bureau.

A.3.7.1.11 Support and maintain the process to generate and mail EPSDT notification letters for all eligible children who are due for screenings (future and past-due), as defined and on a schedule approved by the Bureau. Follow procedures for returned mail process if notices fail to get delivered.

A.3.7.1.12 Support and maintain the process to generate and mail notification letters for all eligible children who have missed an EPSDT screening, as defined and on a schedule approved by the Bureau. Follow procedures for returned mail process if notices fail to get delivered.

A.3.7.1.13 Maintain the functionality to allow users to generate EPSDT letters using an online application.

A.3.7.1.14 Retain and display information related to the EPSDT notices.

A.3.7.1.15 Maintain functionality to produce EPSDT reports on a schedule as defined by the Bureau. Report details are described in the PWB Technical Design within the EPSDT functional area.

A.3.7.1.16 Produce quarterly and annual CMS-416 EPSDT Reports. The federally required reports list basic information pertaining to participation in the child healthcare program. The information is used to assess the effectiveness of the Bureau's EPSDT program in terms of the number of children, by age group and basis of Medicaid eligibility, who receive child health screening services, who may be referred for corrective treatment, and who receive dental, hearing, and vision assessments.

A.3.7.1.17 Generate EPSDT notification letters from eligibility files for all eligibles due for screenings, as defined and on a schedule developed by the Bureau.

A.3.7.2 EPSDT Inputs and Outputs

This table lists information about specific files that are used in the EPSDT process: The Contractor shall be required to maintain the processes that utilize these files.

EPSDT Interface	Entity/ Vendor	Input/ Output	Freq	Destination/Info/Description
EPSDT Subsystem DOH Immunization Registry	DOH	Input	Weekly	These files are received weekly from Department of Health. These files contain immunization information for newly eligible recipients and recipients who have received immunizations. The immunization data is displayed on the Immunization Screening window for the requested recipient.
MCO EPSDT Screening file	Facilities Manager	Output	Monthly	These are the Managed Care Organization (MCO) files that are generated monthly.
DOH Immunization Registry	Facilities Manager	Output	Weekly	These files are transmitted weekly to Department of Health (DOH). These files contain immunization information for recipients who have received immunizations. DOH uses this data to update their immunization registry.

A.3.7.3 EPSDT Bureau Responsibilities:

A.3.7.3.1 Notify the Contractor and MCOs of any changes in federal or State requirements.

A.3.7.3.2 Provide information to the Contractor concerning EPSDT data or processes, (e.g., covered services, referrals to enrollees and families or caregivers) that may necessitate systems or procedure changes.

A.3.7.3.3 Monitor Contractor EPSDT processes (e.g., file updates, notice generation), through on-line inquiries and audits to ensure contractual compliance.

A.3.7.3.4 Monitor Contractor EPSDT documentation to ensure contractual compliance.

A.3.8 Medicare Buy-In

The Medicare Buy-In function maintains and reports Medicare premium data for dually eligible (Medicare and Medicaid) recipients who have their Medicare premiums paid by the Bureau. The Bureau interfaces directly with SSA to receive and send Medicare Buy-In eligibility information. The Buy-In data is maintained on the interChange system, and the Financial and Accounting function processes the enrollee's premium payment. The interChange TCMIS also facilitates reporting, maintenance, and online access to current and historical Medicare Buy-In information.

A.3.8.1 Medicare Buy-In Contractor Requirements:

A.3.8.1.1 Develop and maintain the capability to update, maintain, and allow online access

to current Medicare Part A and Part B Buy-In, and all other available Medicare information by enrollee.

A.3.8.1.2 Develop and maintain the capability to update, maintain, and allow online access to historical Medicare Part A and Part B Buy-In, and all other available Medicare information by enrollee.

A.3.8.1.3 Maintain functionality to process transactions and generate premium payments for Medicare "Buy-In".

A.3.8.1.4 Using data-match criteria defined by the Bureau identify enrollees for potential Buy-In.

A.3.8.1.5 Generate automatic accretion, discontinuation, and/or re-accretion requests for Medicare, as applicable.

A.3.8.1.6 Develop and maintain an automated audit trail file of all Buy-In transactions.

A.3.8.1.7 Develop and maintain functionality to transmit Buy-In requests to CMS, in a compatible format.

A.3.8.1.8 Process premium payment billings from CMS (Medicare), and update the Buy-In files accordingly.

A.3.8.1.9 Generate, and forward to the Bureau, Buy-In error and audit trail reports.

A.3.8.1.10 Produce Buy-in balancing reports showing discrepancies between SSA records and Bureau records.

A.3.8.2 Medicare Buy-In Inputs and Outputs

The following table lists information about specific files that are used in TCMIS Medicare Buy-In processing. The Contractor shall be required to maintain the processes that utilize these interface files.

Medicare Buy-In Interface Table

Buy-In Interface	Entity/ Vendor	Input/ Output	Freq	Destination/Info/Description
Part A Billing Tape	CMS	Input	Monthly	TennCare
Part B Billing Tape	CMS	Input	Monthly	TennCare
MMA Part D	CMS	Input	Monthly	TennCare
Premium S44 Tape (Part A)	TennCare	Output	Monthly	CMS

Buy-In Interface	Entity/ Vendor	Input/ Output	Freq	Destination/Info/Description
Premium 440 Tape (Part B)	TennCare	Output	Monthly	CMS
MMA Part D	TennCare	Output	Monthly	CMS

A.3.9 Accounting/Financial/Premium Management

A.3.9.1 Accounting/Financial Management

Accounting and Financial Management includes all of the activities associated with processing, distributing and accounting for all payables and receivables of the Bureau of TennCare, the reconciliation of those accounts, and reporting for those activities.

The Department of Finance and Administration (F & A) is responsible for the preparation and administration of the executive budget, must account for State revenues and expenditures, and performs a general planning program for the State. F & A must have access to critical financial information, including accounts payable data, accounts receivables data, business contracts, budget, premiums, drug rebates, and the draw down of federal funds. The Accounting and Financial management function must also support processing for all financial payment transactions including provider, MCCs, Medicare Buy-in, Health Insurance Premium Payment (HIPP), and enrollee refunds and reimbursements.

The Contractor shall maintain an Accounting and Financial Management Application software which includes general ledger, accounts payable, and accounts receivable components to support the business processes of the Accounting and Financial Management unit.

The interChange accounting function facilitates key processes using the Oracle Accounts Payable and General Ledger. It records payment information in the Oracle Payables, and processes journal entries, budget imports, and financial reporting in the General Ledger.

The interChange financial function encompasses provider claim payment processing, accounts receivable and payable processing, and all other financial transaction processing. It ensures that all funds are appropriately disbursed for claim payments and that all post-payment transactions are accounted for and are applied correctly. Claims payable include capitation payments, fee-for-service, administrative fees and disbursements and premium refunds, that are printed and mailed by the Contractor. Transactions are generated to STARS for the production of payments (both electronic and paper), for each provider who has had claims adjudicated or who has had financial transactions processed.

The iC TCMIS supports Electronic Funds Transfer (EFT) payment methods through the STARS system. Although payments are disbursed by STARS, provider and MCC remittance advice(s) are produced by iC during the Claims process and are distributed by the Facilities Manager. The interChange financial function tracks the payments associated with remittance advices by receiving and posting transactions from STARS history.

A.3.9.2 Premium Management

TennCare Standard enrollees with income above one hundred percent (100%) of the Federal Poverty Level (FPL) shall pay a share of the cost of their health care services. TennCare

Standard cost sharing occurs in two (2) ways: monthly premiums, and co-pays for specific services. Pharmacy co-pays shall apply to TennCare Standard enrollees as well as certain non-institutional Medicaid adults.

The Premium Management function facilitates the calculation of enrollee premiums, billing of enrollee premiums, the application of premium payments and premium collections. It ensures that enrollee premiums are calculated properly and that all premium receipts are accounted for and applied accurately to the enrollee premium receivables.

When a recipient becomes eligible in a category that requires them to assist in the cost of their care (e.g., TennCare Medically Eligible), DHS calculates the premium amount that they shall be required to pay, and forwards this information to the TCMIS. The Premium billing process is currently done within the interChange Oracle Financial function. Letters advising new enrollees of premium amounts and payment schedules are sent from Department of Human Services (DHS) eligibility system. Premium statements, notices of changes in premium amount, past due notices, notices of pending termination due to late payment, and termination notices are sent from the TCMIS. Due to income or status changes, enrollee premium appeals often result in write-offs of the premium amount.

A.3.9.3 Adjustments and Recoupments

Adjustments to payables and receivables include applying MCC payment withholds, penalties and releases, premium refunding and write-offs, drug rebate receivable adjustments, and bankruptcy adjustments for enrollees, contractors, and providers. The financial change request (FCR) process is used to post deduction adjustment amounts from future payments.

Recoupments are credits due the Bureau from Managed Care Contractors and providers that include overpayments, penalties, and assessments levied for contract performance issues.

Additional information for the current Accounting and Financial processes can be found in the interChange Project Work Book (PWB) under these functional areas.

A.3.9.4 Accounting/Financial/Premium Contractor Requirements:

A.3.9.4.1 Support the Premium Management component of the TCMIS to sustain premium management receivable processing including enrollee refunds, monthly enrollee premium billing, posting premium receipts from enrollees, and maintenance of accurate premium account balances. The Premium management component has an automated interface with STARS (or Edison when implemented), and Oracle (accounting and financial system).

A.3.9.4.2 Support the Accounting and Financial Management Application that facilitates processes including general ledger, accounts payable, and accounts receivable components, maintaining the financial interfaces and processes that integrate the application with related TCMIS and STARS (or Edison when implemented) functions.

A.3.9.4.3 Maintain flexible premium rate tables by aid category, family size, and income level.

A.3.9.4.4 Maintain calculations for initial and monthly premiums for specified eligibility categories and/or benefit programs, based on the enrollee's eligibility category,

family size, income, and the income percent of the Federal Poverty Level for the enrollee.

A.3.9.4.5 Maintain the functionality to generate "past due" premium notices and "pending termination" notices at variable intervals.

A.3.9.4.6 Maintain functionality to select, validate, and apply the correct premium rate to each monthly premium statement.

A.3.9.4.7 Maintain the functionality to suspend billing member premiums through an online update (e.g., for periods of time covered by bankruptcy or appeals).

A.3.9.4.8 Maintain capitation (both administrative fee and at-risk payments to MCCs) information.

A.3.9.4.9 Maintain the capitation rate payment history, including initial payments, retroactive adjustments, and associated rate files.

A.3.9.4.10 Maintain data available for calculation of capitation to MCCs.

A.3.9.4.11 Maintain capitation rate change history with effective date processing.

A.3.9.4.12 Maintain multiple capitation rate calculation methodologies including full risk and partial risk, carve outs, specialty care capitation methods, per-diem rate methods, and primary and specialty capitation rate payment methods.

A.3.9.4.13 Maintain multiple capitation rate pro-ration methodologies including daily, weekly, semi-monthly, monthly rate payment segments, and pro-rations (e.g., when an enrollee is enrolled before or after a certain date of the month or change in eligibility categories because of age).

A.3.9.4.14 Maintain functionality to calculate capitation rates specific to each Managed Care Contractor within associated beginning and ending dates of the period, eligibility category, and rate cells valid during the period.

A.3.9.4.15 Maintain functionality to track and report capitation payments with payment dates on file.

A.3.9.4.16 Maintain functionality to allow query access to the MCC capitation data files to view the capitation payment amount and any adjustments that have been made to this rate, the reason for the adjustment, and the date of the adjustment for analysis and reporting purposes.

A.3.9.4.17 Maintain functionality to calculate capitation rates for each benefits schedule within a single Managed Care Contractor.

A.3.9.4.18 Maintain functionality to allow the same contractor and/or provider to be paid both capitation and fee-for-service concurrently for different enrollees, enrollees, and services.

A.3.9.4.19 Maintain process to generate and apply adjustments to past capitation payments based on retroactive adjustments to enrollee eligibility, enrollment periods, changes in eligibility categories that affect rates paid, changes in rate categories, contracted rate changes, and enrollee death or retroactive termination from enrollment. The adjustments generated shall be incorporated into the payment and disbursement adjustment process and remittance advice.

A.3.9.4.20 Maintain table driven algorithms for allocating payments to fund types supporting the ability to assign all payments to State and federal chart of accounts categories and account numbers.

A.3.9.4.21 Maintain process to interface with STARS (or Edison when implemented) and to send and receive financial transaction files, budget data, expenditures, and reconciliation information files according to schedule.

A.3.9.4.22 Maintain process to post adjustments (write-offs) and identify the reason and source for the adjustment.

A.3.9.4.23 Maintain the process to track fee-for-service providers in the TCMIS who are in the process of bankruptcy and identify the type of bankruptcy (Chapter 7, 11, or 13).

A.3.9.4.24 Maintain process to suspend billing for provider recoupments in process and cease making payments to providers.

A.3.9.4.25 Maintain process to generate second invoices, retain copies, and provide online viewing of the drug rebate invoices.

A.3.9.4.26 Maintain process to generate second invoices, retain copies, and provide online viewing of all financial invoices.

A.3.9.4.27 Maintain process to generate an audit log for the purpose of tracking expenditures.

A.3.9.4.28 Support processes to interface with STARS (or Edison when implemented) and interChange TCMIS financial data and output payments into the chart of accounts in the State's accounting system.

A.3.9.4.29 Balance and reconcile output payments.

A.3.9.4.30 Maintain process to generate a FCR and identify the financial action to be taken.

A.3.9.4.31 Maintain financial audit and control capabilities.

A.3.9.4.32 Maintain process that generates payments for deceased members through the end of the month even when the member dies during the month for enrollees in the PACE program.

A.3.9.4.33 Maintain process to track and report all record change events and maintain an

audit trail, and provide online access by approved users.

A.3.9.4.34 Maintain the ability to display an unlimited number of event occurrence changes in date order.

A.3.9.4.35 Support process to post partial payments and overpayments to the appropriate records.

A.3.9.4.36 Provide system support for basic financial and accounting functions and reporting capabilities.

A.3.9.4.37 Maintain functionality to recognize retroactive and current changes made to the eligibility file that would affect capitation adjustments.

A.3.9.4.38 Maintain functionality to generate quality control management reports to support capitation cycle integrity and error detection with balancing features.

A.3.9.4.39 Support functionality to record liquidated damages for MCCs, carry the reason code on the record and calculate and post adjustments immediately.

A.3.9.4.40 Maintain functionality to generate provider payments through ACH funds transfers sent through the State's Accounting system.

A.3.9.4.41 Maintain process to generate disbursement transactions through STARS (or State's Accounting system), to support electronic funds transfer (EFT) or Journal Vouchers to Bureau business partners such as banks, contractors, government agencies, and providers, according to the guidelines established by F & A.

A.3.9.4.42 Identify the voluntary election of EFT by the payee and schedule EFT transfer.

A.3.9.4.43 Ensure that the CMS-21 report is generated according to the Bureau's schedule.

A.3.9.4.44 Ensure that the CMS-64 report worksheets (hardcopy and media reformatted to AP/AR Report format) are generated according to the Bureau's time schedule.

A.3.9.4.45 Ensure that the MSIS (CMS-2082) report is produced according to the Bureau's schedule.

A.3.9.4.46 Operate the Bureau's Financial Management functions effectively, efficiently, and in compliance with the performance standards and applicable State and federal policy, law, and regulation.

A.3.9.4.47 Provide and maintain staff knowledgeable in policy and procedures as they pertain to the financial management requirements of the Bureau program.

A.3.9.4.48 Produce, as needed, and maintain comprehensive, accurate, written procedures documenting all major aspects of the financial management system and procedures followed by the Contractor's staff and management.

A.3.9.4.49 Provide and execute quality assurance procedures to ensure that the Financial Management system disburses, tracks, and accounts for the Bureau payments accurately.

A.3.9.4.50 Produce provider payment transactions for output to the STARS (or Edison when implemented) system in hardcopy and/or media format that have been initiated through the State's accounting system in the manner and on the schedule set by the Bureau.

A.3.9.4.51 Produce remittance statements (hard copy and electronic) and mail, transmit, or dispatch to the correct providers and business partners.

A.3.9.4.52 Present messages on the remittance statement in a non-technical language that is understandable to providers and contractors, especially in regard to pended and denied claims, adjustments and recoupments.

A.3.9.4.53 Generate a payment register to the Bureau and the STARS (or Edison when implemented) system at the end of each claims payment cycle, as specified by the Bureau.

A.3.9.4.54 Update claims history and financial files with the check number, date of payment, and amount paid after the claims payment cycle.

A.3.9.4.55 Perform adjustments to original and adjusted claims and maintain records of the previous processing.

A.3.9.4.56 Provide for the proper handling of returned checks, including the appropriate fee for insufficient funds.

A.3.9.4.57 Develop the capability to split or reduce payment amounts not yet released for reasons such as last-minute fraud and abuse holds, court orders or funding issues.

A.3.9.4.58 Develop and maintain process to report principal and interest amounts owed by providers, drug labeler, or other organizations on accounts receivable.

A.3.9.4.59 Provide twenty-four (24) hours per day, seven (7) days per week online access to financial information, including claims, capitation, premium, and provider payment information.

A.3.9.4.60 Prepare and submit a report to the Bureau separately listing all inappropriate and/or incorrect payments.

A.3.9.4.61 Update and maintain financial transaction balances of paid and collected amounts for each provider, MCC, and all other entities.

A.3.9.4.62 Receive and correctly process fee-for-service and crossover claims payment and issue payment (check or EFT) through STARS (or Edison when implemented) and produce the Remittance Advice.

A.3.9.4.63 Produce and mail enrollee premium statements and notices to enrollees.

A.3.9.4.64 Bill for premiums due from uninsured and uninsurable enrollees.

A.3.9.4.65 Collect and post premium payments and adjustments. The previous Facilities Manager contracts with a bank to do the collections through a "lock box" and provides a tape of the payment transactions.

A.3.9.4.66 Provide for distributing of special fund pools as directed by the Bureau. Additionally, review the special funds pool calculation and distribution process and propose improvements to the Bureau.

A.3.9.4.67 Operate the Accounting/Financial functions to ensure that all Bureau funds are appropriately disbursed for claims payments and that all post-payment transactions are applied accurately.

A.3.9.4.68 Operate the Claims Reporting and Financial component of the TCMIS, including any improvements or enhancements as they are implemented or as required by the Bureau.

A.3.9.4.69 Maintain an automated interface with STARS (or Edison when implemented), to support direct data transfers.

A.3.9.4.70 Complete the weekly payment cycle within established time frames so that provider payments and provider claim reports can be made available in a timely manner.

A.3.9.4.71 Maintain functionality to process and generate managed care payments for managed care providers.

A.3.9.4.72 Update the claims history file/database with the warrant numbers, date of payment, and amount paid information.

A.3.9.4.73 Perform all internal balancing activities to ensure accurate disbursement of payments, as defined by the Bureau.

A.3.9.4.74 Provide online access to claims.

A.3.9.4.75 Provide functionality to update financial information.

A.3.9.4.76 Update system and operations documentation when system changes are made.

A.3.9.4.77 Develop and maintain functionality to process files received from collection agency and reverse claims that have been recouped.

A.3.9.5 Modification of Functionalities Requirements:

The following requirements are functionalities that shall be developed and implemented by the Contractor after Bureau approval.

A.3.9.5.1 Sixty (60) calendar days after the Contractor assumes TCMIS operations, July 1, 2009, the Contractor shall develop a cost allocation plan that properly identifies all costs under the contract by category of Federal Financial Participation (FFP) and provides documentation to support the State's claim for Federal Financial Participation (FFP) in accordance with State Medicaid Manual, Part 11. The State shall utilize the Contractor's cost allocation plan in conjunction with TennCare's cost allocation data to prepare TennCare's cost allocation plan and submit to CMS for approval. The Contractor shall be responsible for production of monthly reports to account for categories of expenditure to the federal government. The Contractor shall be expected to automate more of the administrative and operational processes, thus increasing the State's overall FFP rate.

A.3.9.5.2 Contractor shall review the current financial change request (FCR) process and recommend improvements.

A.3.9.5.3 Develop and maintain procedures to process federal reimbursements (e.g., when providers do not cash checks).

A.3.9.5.4 Develop process to systematically generate letters for Accounts Receivables showing principle and interest.

A.3.9.5.5 Maintain and modify the MCC withhold percentages as directed by the Bureau.

A.3.9.5.6 Maintain Disproportionate Share Hospital (DSH) reporting to include receiving patient census information from providers in a format approved by the Bureau and compare the census information to TennCare eligibility and provide the results to the Bureau and providers.

A.3.9.5.7 Maintain functionality to systematically generate a dunning summary to request payment of outstanding Accounts Receivable, and also maintain letter history.

A.3.9.5.8 The Bureau intends to acquire HIPP capabilities to pay insurance premiums for employer and government sponsored health insurance and purchase variable benefit packages for different eligibility categories. The Contractor shall need to incorporate this automated functionality, if required.

A.3.9.6 Accounting/Financial and Premium Inputs and Outputs

A.3.9.6.1 Accounting/Financial Inputs and Outputs

The following table lists information about specific files that are used in the Accounting and Financial processes that the Contractor shall be expected to maintain:

Accounting/Financial Interface	Entity/ Vendor	Input/ Output	Freq	Destination/Info/Description
Accounting Bank Reconciliation	F&A Accounts State Data Warehouse	Input	Weekly	Oracle Cash Management/ Bank reconciliation information (e.g., cleared date, cleared amount) sent from State Data Warehouse to Oracle Financials. Input Format = State Data Warehouse Bank Reconciliation Layout
STARS Payment Information	F&A Accounts STARS	Input	Daily	Oracles Payables/ Payment information (check number, check date) will be imported from STARS History File into Oracle Payables Input Format = STARS History Layout
Voids	F&A Accounts STARS	Input	Daily	Oracle Payables/ Information on void payments will be imported from the STARS History File into Oracle Payables. Input Format = STARS History Layout
TennCare Financial Activity	F&A Accounts STARS	Input	Daily	Oracle General Ledger/ TennCare financial activity (including budget information) will be imported from STARS history file into Oracle General Ledger for transactions that originated in STARS and/or have not previously passed through Oracle Financials Input Format = STARS History Layout
Vendor	F&A Accounts STARS	Input	Daily	Oracle Payables/ Additions/updates to vendor information will be imported from STARS into Oracle Payables. Input Format = STARS Vendor Extract File Layout
Payment Request	Oracle Payables	Output	Daily	F&A Accounts STARS/ All Invoices that require payment will be interfaced to STARS. This interface will be scheduled to run once a day and will process any invoices that are in the correct state that have not already been interfaced to STARS.

Accounting/Financial Interface	Entity/ Vendor	Input/ Output	Freq	Destination/Info/Description
				Output Format = STARS Transaction Layout
Financial Transactions to STARS	Oracle General Ledger	Output		F&A Accounts STARS/ Summary financial transactions will be sent from Oracle General Ledger to STARS for any financial activity in Oracle that has not been previously sent. Output Format = STARS Transaction Layout
Financial Subsystem STARS History File	STARS	Input		This file will be returned from STARS after payments are made. This file will contain payment information such as check numbers, redemption dates and payment amounts. It will also contain cancelled check information.
Check Clears File	State's Data Warehouse	Input		This file will be sent from the State's Data Warehouse to update the interChange check file with the dates that checks have been redeemed.
Special Fund Pool Payouts		Output		This is a file that contains around 3000 payouts to providers and recipients. It will be sent in the STARS direct expenditure format.
Electronic RA		Output		This is the Electronic RA file layout for delivery of the RA to the providers. A provider is defined as any entity who is assigned a provider number within interChange. This can include agencies such as DCS or any of our MCOs, BHOs and ASOs.
Payment File		Output		This is the file that financial sends to STARS with payment information from the check write.
Accounts Receivable File STARS Format		Output	Monthly	This is the file that is sent to STARS on a monthly basis to update the outstanding A/R amounts.
Refund Data File STARS Format		Output		This is the file that is sent to STARS to record refund dollars from the providers.

A.3.9.6.2 Premium Inputs and Outputs

This table lists information about specific files that are used during TCMIS Premium processes. The Contractor shall be required to maintain the processes that utilize these premium management files.

Premium Management Interface	Entity/ Vendor	Input/ Output	Freq	Destination/Info/Description
Case Recipient Information	Eligibility	Input	Daily	Oracle Receivables/ Additions/Updates to the Case; Oracle receives relevant eligibility information, case status and premium information from Eligibility (through the DHS ACCENT system) to populate the Customer Master. Export File Import File Format: Case Interface
AM-South Lock Box Premium Payment File	AM-South	Input	Daily	Oracle Cash Management/ The Standard Oracle Lock Box Process accepts the format generated by the Bank and sent to TennCare. File Format: Lock Box
Case Delinquency Status (Case Status)	Oracle Receivables	Output	Monthly	Oracle Financials to Eligibility identifying termination due to failure to pay premiums. Notification to Eligibility that Case is delinquent when ninety (90) days past due. This is used in the dunning process. File format: Delinquency Status
Dunning Notices (Past Due Notices)	Oracle Receivables	Output	Monthly	Sent to external printers (Axis Direct), Premiums overdue/ Termination File format: Dunning Letters
Premium Statements File	Oracle Receivables	Output	Monthly	Premium Statements; Statements are printed by OIR, then folded, stuffed and mailed by Axis Direct. The standard Oracle Statement Print program generates an output file that is in the correct Print File Format: Premium Statements
Premium Refunds - STARS Format (TC105)	Oracle Receivables	Output	Daily	STARS Transaction TC105

A.3.9.7 Accounting/Financial/Premium Bureau Responsibilities:

A.3.9.7.1 Enter all Bureau contracts into the TCMIS to produce a log of contracts and obligations for various time periods.

A.3.9.7.2 Review and reconcile any financial discrepancies between the TCMIS and STARS (or Edison when implemented).

A.3.9.7.3 Monitor the TCMIS financial expenditure transactions and reports for accuracy and report any system errors identified.

A.3.9.7.4 Enter all Corrective Action Plans, MCC On Request Reports (ORRs) and MCC Ad Hoc Reports (AHRs) into the case-tracking component of the TCMIS and monitor to completion.

A.3.9.7.5 Enter all directives into the case-tracking component of the TCMIS and monitor all directives arising out of an appeal through to completion.

A.3.10 Drug Rebate

Under the Medical Assistance Program, a rebate agreement between drug manufacturers and CMS authorizes reimbursements for outpatient drugs. The agreements define the rebate amounts that the manufacturer agrees to pay each state for their drugs dispensed and paid for by the state. The per unit rebate amounts are distributed electronically by CMS to each state. The Bureau invoices drug manufacturers quarterly for the units of drugs that are dispensed in each quarter.

The Bureau contracts with a Pharmacy Benefits Manager (PBM) to provide point-of-sale pharmacy services for outpatient and long term care dual eligibles, judicial and state only populations, and BHO prescription drugs. Drugs dispensed by Managed Care Contractors are not currently included in the rebate program, with the exception of home infusion therapy.

During the quarterly Drug Rebate cycle, the CMS rate file is processed to produce original and replacement invoices for labelers which have had claims for National Drug Codes (NDCs) adjudicated in the prior quarter.

A.3.10.1 Drug Rebate Contractor Requirements:

A.3.10.1.1 Maintain the functionality to support drug rebate processing.

A.3.10.1.2 Maintain the pharmacy formulary to facilitate calculation of drug rebates.

A.3.10.1.3 Maintain a process to calculate drug rebates, create an electronic claims file for rebate data and invoices. Develop and maintain a process to allow manufacturers to access the rebate files and invoices by FTP and notify the manufacturers when the rebate files and invoices are available.

A.3.10.1.4 Maintain process to track and report drug rebate receivables month-to-month (aged accounts receivable) based on monthly cash deposits and report information, as defined by the Bureau.

A.3.10.1.5 Maintain process to adjust rebate rates and post previous period voids and adjustments.

A.3.10.1.6 Monitor the status of each accounts receivable; including enrollee, provider, contractor, and Drug Rebate. Report monthly, quarterly, and on request to the Bureau in aggregate and/or individual accounts, both on paper and online as directed by the Bureau.

A.3.10.1.7 Operate the Drug Rebate Subsystem of the TCMIS, including improvements/enhancements as they are implemented.

A.3.10.1.8 Maintain a drug manufacturer data set for processing drug rebate invoices (currently received from CMS).

A.3.10.1.9 Develop, store online, and maintain drug data that includes, but is not limited to, unit price, package price, billable drug form, rebate eligible drug form, rebate eligibility indicator, and packaging information.

A.3.10.1.10 Develop, enhance, and maintain outlier reports on current and historical claims, on a schedule and as defined by the Bureau.

A.3.10.1.11 Develop and maintain the capability to correct and recreate drug rebate invoice.

A.3.10.1.12 Maintain and produce all drug rebate reports, on a schedule and as defined by the Bureau.

A.3.10.2 Modification of Functionalities Requirements:

The following requirements are functionalities that shall be developed and implemented by the Contractor after Bureau approval.

A.3.10.2.1 Develop and maintain process to calculate interest rates for late drug rebate receivables.

A.3.10.3 Drug Rebate Inputs and Outputs

This table lists information about specific files that the Contractor shall be expected to maintain during the Drug Rebate processing. Refer to Attachment D - Glossary for acronyms, if needed.

Drug Rebate Interface	**Entity/ Vendor**	**Input/ Output**	**Frequency**
Drug Rebate System CMS Labeler File	CMS	Input	Quarterly
CMS Rate File	CMS	Input	Quarterly
Supplemental Rate File	TennCare	Input	Quarterly
PBM Claims Payment Denial File	PBM	Input	Weekly

Drug Rebate Interface	Entity/ Vendor	Input/ Output	Frequency
PBM Encounter Extract File	PBM	Input	Quarterly
Electronic PQAS	Labelers	Input	Quarterly
Electronic ROSI	Labelers	Input	Quarterly
CMS Rebate File	CMS	Output	Quarterly
Drug Rebate Invoices	Labelers	Output	Quarterly
Drug Rebate A/R File – STARS Format	STARS	Output	Monthly
Data Niche File	Data Niche	Output	Quarterly

A.3.11 Claims/Encounter Claims

The purpose of the Claims and Encounter Claims business process is to ensure that fee-for-service (FFS) claims from enrolled providers, and encounter claims data from Managed Care Contractors are received, tracked, processed, adjudicated, and reported accurately and in a timely manner. Data from Reference, Provider, Eligibility, Enrollment, Third-Party payers, Claims History, Financial Transactions, and Prior Authorization are utilized in processing FFS claims. Claims may be received electronically or on paper. Data from Reference, Provider, Eligibility, Enrollment, Third-Party payers, and Encounter History are utilized in processing encounter claims.

A.3.11.1 Summary of Current Processes

The current interChange system processes both FFS claims and encounter claims. Providers who are approved and enrolled in TennCare submit claims using several methods for claims submissions, and through various resources:

1) Online web entry: Web submissions process single line claims (UB92 functions). Electronic submission of claims is being done using a Turnaround Document (TAD)-like submission process. This direct data entry utilizes a front-end process that utilizes an electronic TAD-like claim format. This allows submission of claims one (1) at a time, and relates to a 'behind the scene' data entry mechanism.

2) Paper.

3) Electronically by (837) batch. Managed Care Contractors use electronic file transfer protocol (FTP) to submit encounter data.

4) Clearinghouses:

Medicare crossovers are submitted using Group Health Incorporated - GHI.

School-based claims are submitted using Maximus.

5) Fee for Service (FFS) claims:

FFS claims are submitted directly from HCBS providers.

FFS claims are submitted from long term care (LTC) providers.

Medicaid: SNF, ICF, and Physician and Laboratory.

6) Other State agencies submit FFS claims:

DCS: Department of Children's Services.

TDMR: Tennessee Department of Mental Retardation (TDMR) pays contracted providers from agency-designated State funds, and then TDMR bills the Bureau directly.

MHDD: Psychiatric Institutions within the Department of Mental Health and Developmental Disability (MHDD) submit claims for inpatient services directly to the Bureau.

The iC TCMIS uses one (1) translator and multiple companion guides to govern all transactions. All claims and encounters are entered into the same claims engine, and they are stored in the same file. When performing extracts, splitter programs shall use the designation type to differentiate between claims and encounters.

Claims and Encounter processing functions ensure claims for eligible enrollees, received from enrolled providers for covered services, are accurately processed and adjudicated in accordance with State and federal requirements. The FFS claims processing function encompasses the tracking and processing of claims transactions on through adjudication. The encounter processing function encompasses the receipt of encounter data, data validation and processing of encounters. The FFS data utilized in claims processing is also used for encounter validation.

A.3.11.1.1 The TCMIS Claims Processing function includes:

a) The Edit/Audit Processing function ensures claim records are processed in accordance with TennCare policy and/or rules.

b) The Claim Pricing function calculates the payment amount for each service according to the rules and limitations applicable to each claim type, category of service, and type of provider.

c) Adjustment Processing supports the adjustment of previously adjudicated claims due to patient liability, TPL recoveries, re-pricing, and so forth.

d) The Claims Resolution function is to support the correction of suspended claims.

e) The Long Term Care Processing function processes claims for the MR, elderly disabled, Home and Community Based Services (HCBS) waivers, PACE, and Long Term Care institutional programs.

f) The Point of Sale (POS) / Prospective Drug Utilization Review (ProDUR) function provides for the online processing of pharmacy claims submitted in real-time by pharmacies and prevents the dispensing of inappropriate drugs through direct intervention. (Note: This is not a requirement, as this function is currently provided by TennCare's PBM.)

A.3.11.1.2 <u>Adjustments</u>

The TCMIS Adjustment process supports the adjustment of previously adjudicated claims due to billing errors, patient liability, third party liability (TPL) recoveries, re-pricing, and so forth. There are many reasons a claim may be changed or adjusted.

Providers initiate adjustments electronically or through correspondence, which is then entered through the adjustment windows. Electronic adjustments are sent in by the HIPAA standard transaction sets through the Electronic Data Interface (EDI) to the Claims subsystem. Provider correspondence comes by various forms through the Imaging subsystem. Provider alterations are recorded in claims history in a way that maintains an audit trail of exactly what was requested or sent. At any time during the claims processing activities, one can determine what actions were taken by the provider for a specific set of services. The adjustment processing of EDI and Imaged correspondence are recorded on the Remittance Advice (RA). The Financial subsystem which produces the RA demonstrates what happened to the provider's claims, financial transactions, and adjustment activities.

Insurance companies send payments for claims for which they were liable. These payments are applied to the claims, which results in an adjustment being processed.

When pricing or policy information needs to be altered, reprocessing of a large number of claims may result. A mass adjustment process occurs when provider per diems are altered. Claims are automatically selected and processed using the adjustment windows. Adjustment clerks may then view the net effect and decide how to complete the mass adjustments. Other criteria may be used to select claims in an ad-hoc approach. Using the same mass adjustment windows, operators may review and process the adjustments with the same controls. With the mass adjustment function, corrections may be made to the various programs to apply retroactive adjustments to historical claims.

Adjustments created through a variety of sources (e.g., entered via windows, TPL recoveries, or through the mass adjustment process), are all recorded in claims history and are reported throughout the iC TCMIS. All the subsystems, such as Claims, Financial, SUR, and MAR, contain special processing functionality to support the adjustment process. These processes ensure accurate recording of claims alterations coming in the form of an adjustment.

A.3.11.1.3 Claims Resolution

The TCMIS Claims Resolution is a process composed of a set of windows and programs that allows an operator to correct a claim before it is adjudicated. When the claims engine completes the edit, audit, and pricing of a claim, a disposition process determines whether the claim pays, denies, or suspends. A resolution supervisor, using a supervisory window, assigns claims in specific locations to clerks using parameters maintained by the resolution supervisor. Using claims data correction windows, resolution staff modifies the claim, and the claim is then resubmitted for correction to be reprocessed by the claims engine. This process is repeated until the claim denies or pays.

A.3.11.1.4 Long Term Care (LTC) Claims Processing

The purpose of Long Term Care (LTC) Claims Processing is to adjudicate claims for services provided in Institutional Programs (e.g. SNF and ICF/MR), in the HCBS waiver programs for the mentally retarded or the elderly and disabled, and in PACE. The claims function for LTC processing is similar to the process described above. Additional processing in recipient validation through the Preadmissions Evaluations (PAE) referral process and audits on claims histories are performed to ensure services are properly rendered.

Payments are estimated based on the previous month's activity. A special internet application, "Web Level 1 Billing", helps ICF and ICF/MR facilities electronically submit UB92/837I compliant claim information on a monthly basis. Additional information on this function may be found in the Internet subsystem. This, in conjunction with the estimated payment, allows for a convenient billing cycle for the ICF and ICF/MR facilities.

SNF facilities may use the Internet UB92 "Web Level 2 Billing" to electronically submit UB92/837I compliant claims. All LTC facilities also have the option to bill paper claims using the UB92 forms or send electronic HIPAA 837I transactions.

Referrals for long term care may come from the applicant, hospital or other medical provider. The Preadmission Evaluation (PAE) form may originate from multiple sources within the healthcare community, including the applicant hospital or other medical provider. The PAE shall be completed by a nurse, physician or physician assistant.

A.3.11.1.4.1 Preadmission Evaluation (PAE) - The Division of Long Term Care (DLTC) processes thirty thousand (30,000) to thirty-two thousand (32,000) PAEs per year for individuals seeking Medicaid reimbursement of nursing home care, ICF/MR services, HCBS waiver programs, and PACE services. This number also includes level of care change requests for nursing facilities, transfers from one (1) facility to another, and transfers between institutional and waiver programs.

A.3.11.1.4.2 Quality Assurance – A Quality Monitoring Unit monitors quality of care in waiver and institutional programs. The Department of Health conducts surveys and certifications of SNFs and ICF / MRs.

A.3.11.1.4.3 LTC Appeals - A PAE (medical eligibility) appeal may occur for HCBS waivers, PACE and nursing facility or ICF/MR applicants when the PAE is denied. A denial may also result in an appeal if the denial was based on a Pre-Admission Screening and Resident Review (PASARR) finding, which indicates the need for specialized services.

A.3.11.1.4.4 PAE Appeal Process - About five hundred to six hundred (500 – 600) PAE appeals are received each year, but usually less than fifty (50) PAE hearings occur per year. PAE appeals are processed in accordance with the *Doe v. Word* and *Doe v. Ferguson* federal court orders. The Bureau staff schedules the hearing with the Administrative Procedures Division and the TennCare Office of General Counsel (OGC). The OGC litigates these appeals and the initial hearings are heard by an Administrative Law Judge (ALJ). PAE nurses conduct onsite visits and serve as State witnesses at appeals hearings. There is a ninety (90) day time limit to complete the appeal process. If the time limit is missed, the Bureau shall pay for services even if the service(s) is/are denied by an ALJ. The time period is extended if the applicant requests a hearing continuance.

A.3.11.1.4.5 Billing/Payments - LTC claims include ICF (Level I), ICF/MR and SNF (Level II) claims. As of the Contract Start date, ICF and ICF/MR claims are billed using the web-based Turn Around Document (TAD-like claims) submission. SNF claims are billed using electronic UB92. In interChange, all LTC claims are billed using HIPAA 837I transactions/UB92.

LTC claims are billed to the Bureau by LTC facilities and are processed as Fee-for-Service (FFS) claims in interChange. Payment for these services is to the individual service providers.

ICF and ICF/MR facilities receive an estimated payment each month. The financial functional area generates estimated payments to LTC facilities based on the activity for the previous month. The Financial function sets up an advance expenditure/Accounts Receivable once a month for each ICF and ICF/MR facility. The ICF and ICF/MR claims are applied against the Accounts Receivable.

SNF claims are not paid in advance. These claims are processed as they are submitted, adjudicated and then paid during each financial payment cycle.

The TennCare Claims Unit is responsible for monitoring provider claims payment, provider education (for claims processing and policy), initiating voids/adjustments to payments, and for providing technical assistance to nursing homes.

A.3.11.2 Capitation Payments

Monthly capitation payments are made to Managed Care Contractors (MCCs) for approximately one million, two hundred thousand (1,200,000) enrollees, including six hundred forty thousand (640,000) children. As of the Contract Start date, payment transactions are generated to eight (8) MCOs and two (2) BHO Contractors. Planned changes include creating additional BHO assignments, for alignment with each of the MCOs.

Administrative fees are paid to a Dental Benefits Manager (DBM) for processing dental claims, and a Pharmacy Benefits Manager (PBM) for processing drug claims for the dual eligible population, some behavioral health enrollees, and special needs populations.

Capitation payment rosters (X12 820 transactions) are generated and distributed through an electronic file transfer to the Managed Care Contractors. The posting of payments is interfaced to STARS.

Whenever capitation adjustments are needed, either manual adjustments may be performed through online maintenance, or automated adjustments are done prior to the monthly capitation cycle batch process.

A.3.11.2.1 MCO Capitation Payment Process

The TCMIS generates monthly capitation payments to each MCO for each eligible recipient enrolled in TennCare. As of the Contract Start date, there are two (2) payment methodologies for MCO capitation payments. For the newest two (2) MCOs, payments are made according to the enrollee's rate category (determined by their aid category, age, gender, and possible priority add-on rate). There are various rate classifications based on the thirteen (13) regional areas. Capitation payments made to the remaining six (6) MCOs are paid by generating payments for administrative fees based on the number of enrollees. Additionally weekly invoices are submitted from these MCOs and payments are generated for actual medical expenses incurred by the enrollees.

If any changes in eligibility have occurred within a twelve (12) month period prior to the Capitation Payment run, payments are adjusted. Edit and audit reports are generated. The payment and adjustment information is passed on to the Claims functional area for processing. Additional information concerning MCO payment methodologies may be found in the individual MCC contracts.

A.3.11.2.2 BHO Capitation Payment Process

Some Behavioral Health Organization (BHO) capitation payments are based on a negotiated annual fixed amount. Payments are paid monthly to each of the BHOs. Higher capitation rates are paid for enrollees referred to as Priority Participants (SPMI/SED) and have had a mental health assessment within the previous six (6) months. After payment amounts are calculated for this population, the balance of the fixed payment fund is divided by the remaining number of enrolled enrollees to derive the capitation rate for the remainder of the enrollees.

A.3.11.2.3 DBM Payment Process

The TennCare Dental Benefits Manager (DBM) is paid based on a fixed administrative fee per member per month (PMPM) for each child eligible for the full dental benefit package, and a lesser fixed administrative fee (PMPM) for all other enrollees eligible for emergency dental benefits. Dental reimbursement payments are also made on a weekly basis for compensation of actual dental expenses incurred by the enrollees. Payments are based on enrollment at the first day of the month, and are not adjusted during the month because of fluctuating eligibility unless the variance is due to a mass transfer of enrollees.

A monthly administrative fee is paid to the Dental Benefits Manager (DBM) for enrolled enrollees, on a per member per month (PMPM) basis.

A.3.11.2.4 PBM Payment Process

Payments to the Pharmacy Benefits Manager (PBM) are based on a PMPM administrative fee based on set fixed amounts for various administrative functions. Pharmacy reimbursement payments are also made on a weekly basis for compensation of actual pharmaceutical expenses incurred by the enrollees.

A.3.11.2.5 PACE Payment process

The PACE program operates under a dual capitation waiver and is designed to operate within each Fiscal Year's budget. There are no benefit limitations for the PACE program. If it is determined that a particular service is needed for an enrollee, the PACE provider uses the capitation fund monies.

The PACE providers receive a per diem payment for each eligible enrollee from the first day of the month through the last day of the month, even if eligibility terminates during the month, (e.g. enrollee dies). A three percent (3%) rate increase is given at the beginning of each Fiscal Year.

A.3.11.3 Claims/Encounter Claims Contractor Requirements:

A.3.11.3.1 Maintain claims/encounter front end edits software to edit all incoming claims/encounter transactions.

A.3.11.3.2 Support tracking and reporting of rejected encounter claims.

A.3.11.3.3 Update claims/encounter edits as routine maintenance and if requested by the Bureau.

A.3.11.3.4 Support the capability to reject single encounters back to the MCCs.

A.3.11.3.5 Support the capability to track the rejected encounters to ensure they were resubmitted by the MCCs.

A.3.11.3.6 The Contractor shall deliver information concerning errors or exceptions directly to the Bureau within a timeframe defined by the Bureau.

A.3.11.3.7 The Contractor shall maintain the Edifecs SpecBuilder, XEngine and Transaction Manager software.

A.3.11.3.8 The Contractor shall correctly apply/upgrade to the most current version of Edifecs SpecBuilder, XEngine and Transaction Manager software, as approved in writing by the Bureau.

A.3.11.3.9 The Contractor shall maintain the Edifecs SpecBuilder software for guideline authoring, publishing and desktop testing, including utilizing the business edits, code sets and other requirements as defined by Bureau business processes.

A.3.11.3.10 The Contractor shall maintain the Edifecs XEngine software for routing, validation, splitting and acknowledgement generation, including, but not limited to, testing/validating for WEDI SNIP error types one through seven (1-7), which includes, but is not limited to: syntax, semantics, code sets, and trading partner specific business rules, as defined by the Bureau.

A.3.11.3.11 The Contractor shall maintain the Edifecs Transaction Manager software to ensure operational integrity and accountability in the transaction lifecycle by tracking both real-time and batch transactions and associated business or system events at each of the key processing points in the TCMIS and then by analyzing this information to provide a complete picture of the transaction lifecycle.

A.3.11.3.12 The Contractor shall utilize Transaction Manager to automate error management and exception handling.

A.3.11.3.13 The Contractor shall deliver information concerning errors or exceptions directly to the Bureau within a timeframe defined by the Bureau.

A.3.11.3.14 The Contractor shall maintain the Detail System Design (DSD), User Manual, Operations Manual and Training Manual for the Edifecs products.

A.3.11.3.15 Ensure that the fee-for-service claims from enrolled providers and encounter claims data from MCCs are received, tracked, processed, paid (if appropriate), and reported accurately and in a timely manner as established by Bureau standards.

A.3.11.3.16 Process FFS claims at least weekly, on a schedule established by the Bureau, or as requested.

A.3.11.3.17 Process accepted claims, adjustments, and voids from various sources through electronic transmission.

A.3.11.3.18 Maintain functionality to provide access to a detailed Remittance Advice (RA) and billing records for SNFs.

A.3.11.3.19 Reimburse FFS providers through EFT according to schedule (e.g., weekly or as determined by the Bureau).

A.3.11.3.20 Receive, track, and adjudicate electronic crossover claims and adjustment claims.

A.3.11.3.21 Maintain the functionality to retrieve and update Medicare information daily for effective crossover claim processing (e.g., access SSA common working file) for access to the data.

A.3.11.3.22 Receive claims data and encounter claims data in a standard HIPAA format (based upon Bureau Companion Guides). Additionally, perform adjustments/voids and capture denied services.

A.3.11.3.23 Provide an action reason code for each recoupment and generate a descriptive explanation message on the RA.

A.3.11.3.24 Maintain edits to identify duplicate or potentially duplicate claim and encounter records in the same and different batch cycles to the standards set by the Bureau and industry standard specifications.

A.3.11.3.25 Maintain the functionality to recognize adjustment and voided FFS claims and encounter claims accurately in the same and different batch cycles.

A.3.11.3.26 Maintain functionality to support capitation payment adjustment reason codes and reason code narratives explaining the reason for the adjustment on the RA.

A.3.11.3.27 Maintain edits for encounter claims for enrollees who have other primary insurance for the Coordination of Benefits (COB).

A.3.11.3.28 Maintain the process to retrieve and store the prescribing provider's ID number on pharmacy data files, when provided.

A.3.11.3.29 Maintain the process to identify each encounter claim within a batch that contains errors and return to the MCC appropriate reason codes. The reason codes may be in narrative form for ease of understanding.

A.3.11.3.30 Maintain processing of electronic TAD-like claims.

A.3.11.3.31 Support electronic claims capture and processing for all claim types.

A.3.11.3.32 Maintain logic and consistency editing to screen the claim before accepting the claims or encounter data into the TCMIS.

A.3.11.3.33 Maintain the process of assigning a unique claim reference number and assign the number that includes date of claim receipt, batch number, and sequence of

claim within the batch.

A.3.11.3.34 Maintain the process to accept, control, process, and report claims separately for Medicaid and State-only and other programs as defined by the Bureau.

A.3.11.3.35 Maintain batch controls and batch audit trails for all claims and other transactions entered into the system and ensure uniqueness of all batches from all sources.

A.3.11.3.36 Maintain an online audit trail record with each claim record that shows each stage of processing, the date the claim was entered in each stage and any error codes posted to the claim at each step in processing.

A.3.11.3.37 Support online inquiry to claims from data entry through adjudication, including pertinent claim data such as pay date, provider type, claim type, and claim status, with access by enrollee ID, provider ID, and/or claim reference number.

A.3.11.3.38 Maintain process to accept claims as hard copy, electronic or any media acceptable to the Bureau from providers, billing services, Medicare Intermediary, Carrier or Durable Medical Equipment Review Contractor (DMERC).

A.3.11.3.39 Maintain production of control and audit trail reports during various stages of the claims processing cycle.

A.3.11.3.40 Maintain process to edit each data element of the claim or encounter record for required presence, format, consistency, reasonableness, and/or allowable values.

A.3.11.3.41 Maintain process to perform automated edit processing using history claims, pended claims, in-process claims, and same-cycle claims.

A.3.11.3.42 Maintain process to provide for each error code and each resolution code an override, force, or deny indicator, and the date that the error was resolved, causing the claim to be forced, or denied.

A.3.11.3.43 Maintain functionality to identify the allowable reimbursement for claims according to the date-specific pricing data and reimbursement methodologies contained on applicable provider, reference, or Bureau specified data for the date of service on the claim.

A.3.11.3.44 Maintain functionality to automatically deduct enrollee deductible amounts, patient liability, enrollee co-payments, and TPL amounts, as appropriate, when pricing claims.

A.3.11.3.45 Maintain process to perform global changes to pended claims based on Bureau-defined criteria.

A.3.11.3.46 Maintain a minimum of three (3) years of adjudicated (paid and denied) online claims history, all claims for "lifetime procedures" for use in edit processing, online inquiry and update, and printed claims inquiries.

A.3.11.3.47 Maintain functionality to provide a purge function to purge inactive records to an archive file based on criteria established by the Bureau.

A.3.11.3.48 Maintain indefinitely on a permanent history archive with key elements of the history claim, the claims that have been purged from active history.

A.3.11.3.49 Maintain process to archive all hard-copy claims, attachments, and other documents using Bureau-standard imaging technology in accordance with Bureau-retention requirements and dispose of the hard copy claim documents in accordance with Bureau -approved procedures.

A.3.11.3.50 Produce required claims/encounter claims reports (both management and detail) in required media, including claim detail reporting, enrollee and provider history requests, and summary screens for claims/encounter claims and related data.

A.3.11.3.51 Maintain edits for each claim record during an edit cycle, and report each edit failure reason on provider remittance statements.

A.3.11.3.52 Maintain functionality to edit and pend each line on a multi-line claim independently (to allow continued processing of other lines) as well as edit and suspense of common area errors.

A.3.11.3.53 Identify, track, and monitor all edits posted to the claim.

A.3.11.3.54 Identify and hierarchically assign status and disposition of claims and encounter claims that fail edits.

A.3.11.3.55 Maintain flexibility in setting claims edits to allow dispositions and exceptions to edits based on variables such as bill/claim type, submission media, provider type, or benefit plan.

A.3.11.3.56 Maintain edits for potential and exact duplicate claims, including multiple provider locations and across provider and claim types, and Bureau-defined financial fund codes and chart of accounts. Develop capabilities to also include cross-references between groups and rendering providers, and categories of service, in accordance with the Change Management process.

A.3.11.3.57 Maintain process to identify and calculate payment amounts according to the fee schedules, per diems and other rates and rules established by the Bureau.

A.3.11.3.58 Maintain process to identify potential and existing third-party liability (TPL) data, including Medicare, and deny the claim if it is for a covered service under a TPL, for applicable claim types.

A.3.11.3.59 Maintain the capability to pend claims for providers based on Bureau-defined parameters.

A.3.11.3.60 Maintain the capability to pay or deny a large volume of claims pended for a provider based on certain criteria, such as services or dates of service.

A.3.11.3.61 Operate the claims processing functions effectively, efficiently, and in compliance with the TCMIS performance standards and within applicable State and federal policy, law, and regulations for all claim types.

A.3.11.3.62 Process all claims, including those from out-of-state providers.

A.3.11.3.63 Prepare and control incoming and outgoing TennCare program mail to ensure claims and other correspondence are picked up and delivered to any site designated by the Bureau, in the most effective and efficient means available.

A.3.11.3.64 Image, sort and prescreen hard-copy claims and attachments, reconsiderations and any accompanying documentation before entering into the system, and return those not meeting required criteria to providers. Track returned claims daily.

A.3.11.3.65 Archive hard-copy claims, and accompanying documentation.

A.3.11.3.66 Manage, perform, and validate Optical Character Recognition (OCR) functions for claims and related inputs to facilitate data entry of all hard-copy claims and attachments.

A.3.11.3.67 Maintain the process to perform validity editing on entered claims and encounters against Provider, Recipient, Financial, Claims History, TPL, and Reference data files.

A.3.11.3.68 Generate and submit claims entry statistics reports.

A.3.11.3.69 Provide appropriate staff to support both technical and informational aspects of EDI. Staff shall be knowledgeable of both the various claims formats (e.g., UB92, CMS 1500, ANSI ASC X12, and NCPDP) and the Medicaid claim processing rules that apply to the various formats.

A.3.11.3.70 Costs for software licenses to provides, as authorized by the Bureau, shall be funded in accordance with Section C.3 Payment Methodology, Paragraph (f) Hardware, Software and Maintenance.

A.3.11.3.71 Maintain system functionality to perform editing for submitted claim data.

A.3.11.3.72 Ensure that claims adjudication is in accordance with medical policies in effect at the time of provision of service.

A.3.11.3.73 Maintain functionality to price claims in accordance with TennCare policies and/or rules, benefits, and limitations as defined by the Bureau.

A.3.11.3.74 Process Medicare coinsurance and deductible charges received on hard copy and electronic media.

A.3.11.3.75 Manually and systematically review and resolve any claims that pend for any of the edits assigned to EDS, as mutually agreed with the Bureau.

A.3.11.3.76 Maintain standard claims control and tracking standards.

A.3.11.3.77 Monitor, validate, and report the use of override and denial codes by Contractor staff during the claims resolution process to identify potential abuse, based on Contractor and the Bureau defined guidelines.

A.3.11.3.78 Maintain functionality to provide online query to active and permanent claims history files and the status of pended claims, including denied claims, to authorized users.

A.3.11.3.79 Provide ongoing training to the Bureau and Contractor staff in the use of the claims processing system and as requested.

A.3.11.3.80 Generate claims entry statistics, EDI claims submission, inventory, and operations reports, and make available to the Bureau in the required format.

A.3.11.3.81 Calculate and report to the Bureau, the encounter claim submittal error rates as compared to MCC standards for encounter claim standards and create a file that can be sent to the MCCs.

A.3.11.3.82 Implement a quality assurance program to review claims processed through the system, to ensure claims resolution and claims adjudication activities are performed in accordance with Bureau-approved guidelines and industry best practices.

A.3.11.3.83 Produce on-line transaction volume reports for all claims, including encounter claims, entered into the system to the batch processing cycle input and output counts. This process should also apply to all claims, TAD 837I interface, and encounter data accepted online real time. Develop report enhancements to include reconciliations and balancing controls and make the information available using the dashboard report tool.

A.3.11.3.84 Generate, review for accuracy, and submit claims inventory and statistical reports after each claims processing cycle.

A.3.11.3.85 Update the claims and encounter entry files daily (as received).

A.3.11.3.86 Retrieve hard-copy claim documentation/correspondence images as requested by Bureau staff, and within the required time frame.

A.3.11.3.87 Perform claims processing activities which include, but are not limited to, mail sort, batching, imaging, data entry, pend resolution, and adjudication.

A.3.11.3.88 Receive and correctly process all claims adjustment requests.

A.3.11.3.89 Process all claims-related electronic transactions.

A.3.11.3.90 Provide hardcopy and/or imaged copies for all requests for claims, attachments, correspondence and applications.

A.3.11.3.91 Receive and process encounters from MCCs. Analyze data quality and provide the Bureau with an assessment and recommendations for corrective action, if appropriate.

A.3.11.3.92 Serve as liaison in managing claims processing with the Bureau's Business Unit responsible for claims processing, the Contractor staff, and Bureau systems team. Participate in change management activities to ensure procedures and processes are updated when system or policy changes are implemented.

A.3.11.3.93 Provide regular reporting of status to Bureau Business Users.

A.3.11.3.94 Process all claims and work with the Bureau to resolve any identified problems.

A.3.11.3.95 Provide claim extracts from online and archived history as necessary to meet the Bureau's needs.

A.3.11.3.96 Develop a monthly report listing separately all Contractor or Bureau identified inappropriate and/or incorrect provider payment, supported by system capabilities and business processes to be developed.

A.3.11.3.97 Monitor claims throughout production, including, but not limited to, claims backlogs, data entry backlog, suspense file status, and other performance measures.

A.3.11.3.98 Monitor claims and inventory balances to determine where backlogs are occurring and report findings to the Bureau.

A.3.11.3.99 Monitor and track claims volume for potential impacts on the contracted fixed price cost estimate.

A.3.11.3.100 Monitor claims processing and provider payments to ensure accuracy of payments and integrity of files.

A.3.11.3.101 Establish controls to ensure no mail, claims, claims attachments, e-mail, faxes, files (electronic or hard copy), or hard media (CDs, DVDs, diskettes) are misplaced after they are received by the Contractor.

A.3.11.3.102 Prescreen hard-copy claims before entering into the system, and return those not meeting certain Bureau-defined criteria (e.g., missing data). Prescreening elements include, but are not limited to: provider identification, enrollee identification, provider signature, and appropriateness of the claim form. Identify all prescreening problems before returning the claim to the provider and maintain copies of claims for audit purposes. Any claims returned to the provider shall include a cross-reference that allows easy retrieval of the returned claim.

A.3.11.3.103 Maintain a daily log of claims returned to providers including documented issue(s) with the claim.

A.3.11.3.104 Provide the Bureau staff full and complete access to the log of claims

and the copies of claims returned to providers.

A.3.11.3.105 Assign unique claim control numbers and unique batch numbers to claims and accompanying attachments such that all claims attachments are attributable to a claim.

A.3.11.3.106 Provide the Bureau, upon request, with electronic or hard copy of claims and supporting documentation (e.g., adjustments, attachments, PAEs, medical records). Provide the number of copies requested whether electronically or via paper.

A.3.11.3.107 Perform a daily quality control sample of the documents imaged that day.

A.3.11.3.108 Conduct a sample audit of all claim types weekly to assure the TCMIS is processing claims correctly.

A.3.11.3.109 Establish balancing procedures and reports to ensure control within the TCMIS processing cycles and reconcile any differences.

A.3.11.3.110 Maintain adequately staffed data entry and resolution units to process claims within the time frames specified by this Contract.

A.3.11.3.111 Perform data entry of all hard-copy claims and claim-related documents with Bureau-approved quality assurance controls.

A.3.11.3.112 Identify and report all claims replacements (e.g. adjustments and reconsiderations) resulting from Contractor processing errors.

A.3.11.3.113 Perform Bureau approved validity editing on all entered claims against provider, enrollee, reference, and other TCMIS data.

A.3.11.3.114 Maintain online inquiry access to claims, adjustments, and financial transactions, from data entry through to payment, with primary access by enrollee ID, provider ID, and/or control number and secondary access including, but not limited to, pertinent claim data and claim status, based on appropriate security.

A.3.11.3.115 Maintain a claims inventory and control system as approved by the Bureau.

A.3.11.3.116 Maintain a permanent record of all claims/encounter claims received. The record shall be accessible online, either from a function within the TCMIS or other separate data storage and access facility (document imaging). Records shall be available for Bureau and other specific agency and auditor review within time frames established by the Bureau.

A.3.11.3.117 Produce inventory management analysis reports by claim type, processing status, and age in suspense that are produced daily, weekly, monthly, and on-request. Additionally, the Contractor shall supply the Bureau detailed

reports on request.

A.3.11.3.118 Produce online and hard-copy balancing and control reports, according to Bureau specifications.

A.3.11.3.119 Make written recommendations on any area in which the Contractor or Bureau thinks improvement can be made.

A.3.11.3.120 Operate the Claims/Encounter Processing component of the TCMIS, including improvements/enhancements as they are implemented.

A.3.11.3.121 Perform all data processing operations to support Claims/Encounter Processing requirements, including, but not limited to: edit processing, suspense resolution, claim pricing, adjudication processing.

A.3.11.3.122 Execute claims/encounters processing cycles and generate outputs on a Bureau-approved schedule, in accordance with the standards approved by the Bureau.

A.3.11.3.123 Process Bureau-approved formats and claim forms.

A.3.11.3.124 Generate and process managed care payments and reconciliation for Managed Care Contractors (MCCs).

A.3.11.3.125 Review and process all claims and other transactions submitted (including both hard-copy and electronic media claims) against the most current and/or appropriate files/database tables.

A.3.11.3.126 Process reconsideration claims, including, but not limited to: traditional reconsiderations (e.g., appeals) and the following: late billing, enrollee retroactive eligibility, out-of-state emergency, payment under court order, result of an appeal/fair hearing, class action suit, and any other Bureau-defined situation, in accordance with Bureau instructions.

A.3.11.3.127 Maintain and periodically test the method to process for payment any specific claim(s) or claim type(s), as directed by the Bureau, on an exception basis.

A.3.11.3.128 Maintain functionality to edit all claims in accordance with TennCare policies and/or rules, benefits, and limitations as defined by the Bureau.

A.3.11.3.129 Price all claims in accordance with TennCare policies and/or rules, benefits, and limitations as defined by the Bureau.

A.3.11.3.130 Provide the Bureau with online inquiry access to current claims status data, based on appropriate security.

A.3.11.3.131 Maintain functionality to provide online access to the claims history file/database.

A.3.11.3.132 Provide online access to suspended claims data and the exception control file defining the disposition of edits and audits.

A.3.11.3.133 Maintain thirty-six (36) months of adjudicated claims and encounter history for all transactions processed to final disposition and for use in editing/auditing claims. The thirty-six (36) month period shall be based on the final disposition date of the claim.

A.3.11.3.134 Provide online access to the thirty-six (36) months of claims history.

A.3.11.3.135 Maintain six (6) years of history for nursing facility paid claims, as prescribed by the Bureau, for processing retroactive rate adjustments. Contractor shall retain the history archive for the term of this Contract, as specified by the Bureau, so that historical claims records can be extracted on an exception basis for audits or other purposes.

A.3.11.3.136 Maintain all claims data elements defined by the Bureau on claims history.

A.3.11.3.137 Maintain an adequately staffed claims resolution unit to resolve claims suspended for edits and audits designated by the Bureau.

A.3.11.3.138 Maintain a collaborative working relationship between the claims resolution unit and the Bureau to develop new edits and audits, write claims resolution instructions, and resolve claims in accordance with program policy and procedures.

A.3.11.3.139 Manually and/or systematically review and resolve any claims that suspend for any of the edits and/or audits as determined by the Bureau.

A.3.11.3.140 Maintain functionality to deny claims with potential third-party payments including Medicare eligibility. Supply the claim submitter and/or provider with instructions and third-party information to facilitate billing the third party.

A.3.11.3.141 Ensure that suspended claims are resolved in accordance with Bureau-approved procedures.

A.3.11.3.142 Process all claims and other claims-related transactions in accordance with the program policy, benefits, and limitations as defined and established by the Bureau.

A.3.11.3.143 Provide an audit trail for all claims from time of claim receipt to time of final disposition so a claim may be located at any time and so that all edits and edit dispositions can be identified. The audit trail shall be stored as long as the associated claim is stored in the online and history database.

A.3.11.3.144 Maintain procedures to identify claims suspended as a result of data entry errors and correct such errors.

A.3.11.3.145 Obtain Bureau approval for all new remittance statements and/or codes developed by the Contractor.

A.3.11.3.146 Maintain and update claims control, exception control, medical criteria, benefit limits, and other parameter files as required and in accordance with Bureau-approved change control procedures.

A.3.11.3.147 Prepare, validate, and distribute operational and performance reports.

A.3.11.3.148 Produce and submit to the Bureau, all required claims and encounter processing reports.

A.3.11.3.149 Maintain functionality to support ability to mass adjust paid claims and re-process denied claims, as requested.

A.3.11.3.150 Update system and operations documentation when system changes are made.

A.3.11.3.151 Develop a plan of action to correct and track to completion errors discovered during the claims and encounter reviews.

A.3.11.3.152 Process all claims and encounters that are required to be reprocessed in the same sequence they were originally processed.

A.3.11.3.153 Provide capability to edit each claim, as far as possible given the information available on the submitted claim, during an edit or audit cycle, rather than ceasing the edit process when an edit failure is encountered. The system shall identify all error codes for claims that fail processing edits at initial processing to minimize the need for multiple re-submissions of claims.

A.3.11.3.154 Provide capability to accept global changes to suspend claims based on Bureau-defined criteria and to release claims to editing.

A.3.11.3.155 Provide for capture and editing of the rendering provider number for all claims.

A.3.11.3.156 Provide editing of all claims, including fee-for-service, encounter, and cross-over, in accordance with Bureau approved edit/audit criteria. Develop and provide control totals and balancing information for processing to ensure that all claims are processed. Provide ability to adjudicate or complete disposition of all claims as either approved, denied, or rejected.

A.3.11.3.157 Provide a review and proposed approach for the adjustment processing (voids/reversals) within the TCMIS to determine the most efficient and accurate methodology for converting the voids and adjustments into financial transactions. Reversing the amounts and units previously paid or recovered and processing the adjustments so they are easily identified and reflected in subsequent reporting and updating.

A.3.11.3.158 Identify and implement Policies and Procedures as they relate to the contractually agreed upon tasks.

A.3.11.3.159 Provide reports and statistics to confirm the successful transfer and loading of claims data and provide control and balancing reports to ensure data integrity during processing.

A.3.11.3.160 Provide the claims processing expertise and technical ability to perform the maintenance and modification activities for adjustments, included shall be the following types of adjustments: adjustments for adjudicated claims; claims specific adjustments; financial adjustments including recoupments, mass adjustments, and cash transactions; retro changes, including retro rate adjustments; all system generated adjustments, including gross adjustments; management fee adjustments; history only adjustments; and automated adjustments from the financial system.

A.3.11.3.161 Collaborate with the Bureau in establishing and maintaining the State Medicaid payment rates and methodology, for Bureau approval.

A.3.11.3.162 Process and generate provider and enrollee claims history requests.

A.3.11.3.163 Provide the Bureau with document imaging, facsimiles, or hard-copy original claims, adjustments, attachments, non-claim transaction documents, and all electronic billings for all transactions processed within five (5) business days, upon request.

A.3.11.3.164 Image claims and any attachments. Process/archive every claim and attachment within one (1) business day of receipt.

A.3.11.3.165 Assign a unique claim reference to electronic media captured claims, voids, and adjustments within one (1) business day of the date received.

A.3.11.3.166 Return within one (1) business day of discovery, claims that have missing or unreadable required data. Any attachments shall be returned with the claims. Instructions for the providers on how to correct and resubmit the returned claims shall be included when the claims are returned to the provider and tracked by an audit trail. All claims correspondence sent to and retrieved from providers shall be imaged and associated with the provider's record. All correspondence shall be stored and retrievable online upon authorized user demand.

A.3.11.3.167 Update claims data resubmitted by providers within three (3) business days of receipt.

A.3.11.3.168 Balancing and control reports shall be viewable online and available for authorized users to account for all claims at all times. All reports shall also be made available through the web portal if requested by authorized users.

A.3.11.3.169 Ensure that the TCMIS meets federal certification requirements defined in the most current version of Part 11 of the State Medicaid Manual. It is

imperative that the TCMIS be complete, stable, fully operational, and of the highest quality. The systems documentation finalized by the Contractor shall be used to support the certification process.

A.3.11.3.170 Ensure that payments are made within thirty (30) days after receipt by the system of an error free claim.

A.3.11.3.171 Generate the remittance statements to providers detailing claims and services covered by a given payment and issue at the same time as the payment.

A.3.11.3.172 Execute production of an explanation of benefits (EOBs) at a frequency defined by the Bureau (e.g., weekly, daily).

A.3.11.3.173 Generate an Recipient Explanation of Medical Benefits (REOMB or EOMB or Daniel's Letters) at least quarterly to every dual-eligible recipient on whose behalf claims have been denied since the last EOMB.

A.3.11.3.174 Maintain functionality to identify claims paid for all services covered by the State plan including: EPSDT, family planning, Medicare deductible and co-insurances paid by Medicaid.

A.3.11.3.175 Maintain functionality to create historical records to be used for input to the Surveillance and Utilization Review and the Management and Administrative Reporting Subsystems.

A.3.11.3.176 Support preparation of payment instruments and their supporting documents.

A.3.11.3.177 Support the field for authorization or identification when an override indicator (force code) is used, as required for certification.

A.3.11.3.178 Develop and maintain the functionality to track and report all provider requests for claims reconsideration. Provide weekly/monthly reporting on all requests.

A.3.11.3.179 Maintain functionality to re-process claims, and provide assistance in claims resolution where research is needed for corrective action.

A.3.11.3.180 Contractor shall evaluate suspended or denied claims for reason of "out of timely filing" to determine if there are any extenuating circumstances.

A.3.11.3.181 Evaluate the use of claims System Assigned Keys (SAKs) and recommend alternative processes to avert systems limitations.

A.3.11.3.182 Ensure that all edits and audits are HIPAA compliant.

A.3.11.3.183 Maintain a fully functional claims resolution staff (who are accountable) to resolve aged suspended and pended claims.

A.3.11.3.184 Develop and maintain test environments needed to emulate production data and code so that the Bureau may test all system edits.

A.3.11.3.185 Develop and produce a report that extracts the data from X12 and is provided in a Bureau designed format when requested by the Bureau. Produce within one (1) business day.

A.3.11.3.186 Generate paper copy of sample RAs for each financial cycle, based on a list of providers supplied by the Bureau.

A.3.11.3.187 Maintain a comprehensive Claims Adjudication Manual for approval by the Bureau.

A.3.11.3.188 Maintain appropriate Bureau review, approval and sign-off procedures for the Claims Adjudication Manual to ensure procedures meet the intent of TennCare policies and/or rules.

A.3.11.3.189 Develop and perform staff training to include plans for cross-training resolution staff in all edits and audits.

A.3.11.3.190 Establish and maintain facility and infrastructure requirements to accommodate a centralized organization for resolution of claims.

A.3.11.3.191 Develop, review, and produce reporting of claims processing metrics for monthly status reporting to the Bureau.

A.3.11.3.192 Develop and maintain functionality to process web interface adjustments.

A.3.11.3.193 Maintain functionality to produce and mail *Daniels* letters.

A.3.11.3.194 Maintain the capability to receive, process, store, and forward HIPAA compliant files and provide HIPAA compliant Remittance Advices.

A.3.11.3.195 Develop and Produce management reports that allow Bureau staff to monitor data from the input source to back-end reporting databases.

A.3.11.3.196 Develop and produce management reports that allow Bureau staff to monitor claims submissions from the input source to the RA. This includes paid, denied, pended, suspended, and flushed claims.

A.3.11.3.197 Contractor guarantees referential integrity within the table structure and not within the coding structure.

A.3.11.3.198 Monitor, review, and update as needed, and work all edits and audits for a claim.

A.3.11.3.199 Assign a unique claim reference number to every paper claim, void, and adjustment within one (1) business day of the date received. Attachments shall receive the same unique number as the document to which it is attached.

A.3.11.3.200 Maintain data entry keying accuracy standards of ninety-nine percent (99%) for claims and other transactions.

A.3.11.3.201 Maintain capability to accept online real time submission of TAD-like claims and encounter data, by portal entry twenty-four (24) hours per day, seven (7) days per week. Online claims, fee-for-service and encounter data shall have a unique claim reference number assigned, including time received, upon entry into the TCMIS system.

A.3.11.3.202 Process, edit, and adjudicate claims and encounters five (5) times per week or as directed by the Bureau.

A.3.11.3.203 Correctly adjudicate ninety percent (90%) of all FFS claims within thirty (30) calendar days of receipt and one hundred percent (100%) of all FFS claims within sixty (60) days of receipt (pay, pend or deny). Additionally, one hundred percent (100%) of clean claims that are received by EDI shall be processed in twenty-one (21) calendar days. One hundred percent (100%) of clean claims that are received on paper shall be processed in thirty (30) calendar days.

A.3.11.3.204 Provide online notification to providers, within twenty-four (24) hours of transmission, regarding any transmission or claim data errors or acceptability for further processing.

A.3.11.4 Modification of Functionalities Requirements:

The following requirements are functionalities that shall be developed and implemented by the Contractor after Bureau approval.

A.3.11.4.1 Develop and maintain the functionality to allow rejected electronic crossovers to be resubmitted from trading partners. The current system requires these to be resubmitted on paper.

A.3.11.4.2 Provide and maintain functionality to reprocess claims that are resubmitted for reconsideration in order to validate payments or for invalid denials for payments.

A.3.11.4.3 Develop and maintain process for tracking, reporting, and adjudicating claims in the “flush file”.

A.3.11.4.4 Reconcile MCC invoices or other control reports and totals to Encounter data received from the MCCs.

A.3.11.4.5 Develop a mass adjustments report that identifies the initiation date and finalized processing date of each mass adjustment for the period.

A.3.11.5 Claims/Encounter Claims Inputs and Outputs

The following table lists information about specific files that the Contractor shall be expected to maintain during the TCMIS Claims and Encounter Claims processing.

Claims/Encounter Interface	Entity/ Vendor	Input/ Output	Freq	Media	Destination/Info/Description
EDI X12 transactions: 837 Professional, 837 Institutional	Providers	Input	Daily / Weekly	EDI or file	837P, 837I Refer to PWB Claims Technical Design
EDI 837 Dental	DBM	Input	Daily / Weekly	EDI	837 D Refer to PWB Claims Technical Design
NCPDP 5.1 Pharmacy	PBM	Input	Daily / Weekly	EDI	Refer to PWB Claims Technical Design
Claims and Encounter Extract	Facilities Manager	Output	Weekly	EDI or file	Health Department, MHDD
Claims and Encounter Extract	Facilities Manager	Output	As Needed	ASCII format	Vanderbilt, Applied Health Outcome-Best Practice, Rational Med-Best Practice, HMS-TPL, University of Tennessee, Price Waterhouse

A.3.11.6 Claims/Encounter Claims Bureau Responsibilities:

A.3.11.6.1 Approve all policies governing data file formats and authorize Contractor modifications.

A.3.11.6.2 Monitor the Contractor through claims review process, cycle balancing and control reports.

A.3.11.6.3 Monitor the Contractor to ensure conformance to federally required electronic data standards.

A.3.11.6.4 Establish Bureau policies and guidelines relating to claims and encounter processing.

A.3.11.6.5 Provide written approval of internal and external claims processing procedures, including requirements of procedures for pricing of FFS claims.

A.3.11.6.6 Approve error override policies, criteria, and procedures for use in claims correction or “special” processing.

A.3.11.6.7 Approve specific edit criteria including edit dispositions.

A.3.11.6.8 Establish claim retention and retrieval standards.

A.3.11.6.9 Review and approve claims submission policies, documentation, and manuals furnished to providers.

A.3.11.6.10 Complete periodic reviews of claims to ensure claims are processing according to policy.

A.3.11.6.11 Submit written recommendations for improvements by the Contractor.

A.3.12 Third Party Liability (TPL)

The Bureau Third Party Liability Unit is responsible for identifying and recovering payments that were made inappropriately. As of the Contract Start date, the Bureau contracts with Health Management System (HMS) to recoup money paid to providers for recipient claims that subsequently were found to have TPL. Since the Bureau is the payer of last resort, payments are collected from the third party resource.

Some of the types of recoveries the TPL Unit is responsible for include: estate recoveries, inappropriate billing recoveries, and Medicare recoupment recovery. The Bureau's TPL Contractor, HMS, facilitates insurance billing, performs credit balance audits, performs Health Insurance Premium Payment (HIPP) processes, collects for inappropriate billing, and performs healthcare data matching for identification and payment of retroactive recoveries. Data matches are performed using Medicare Buy-In data and the interChange eligibility file to check for inappropriate provider payments. The Public Assistance Reporting Information System (PARIS) file is also used in data matches to identify recipients who have eligibility in multiple states, although this is not illegal, which might identify additional claims payment resources.

The TPL Unit works with the Tennessee Bureau of Investigation (TBI), the Attorney General (AG), Office of Inspector General (OIG) and the Office of General Counsel (OGC) to establish prosecutable fraud and abuse cases. Systems updates are applied to the interChange TPL database to maintain carrier information. The source of third party liability data is mainly through DHS, worker's compensation, and independent insurance carriers. The TPL Unit also has the responsibility for managed care monitoring. Training is provided to managed care groups and contractors on how to process claims and adjustments, relative to TPL.

The TPL Unit also drafts State plans and legislative proposals that affect TPL requirements.

A.3.12.1 interChange TPL

The interChange TPL processing function helps the State utilize the private health, Medicare, and other third party resources of its medical assistance recipients, and ensures that Medicaid and the State are the payers of last resort. This function works in several ways:

By collecting, validating, and processing encounter data from the Managed Care Contractors (MCCs) to verify the MCC is fulfilling their contractual TPL responsibilities.

Through data exchanges with the MCCs to ensure both the MCCs and the Bureau have the most current TPL information.

Through a combination of cost avoidance (non-payment of billed amounts for which a third party may be liable) and post-payment recovery (post-payment collection of Medicaid and the Bureau paid amounts for which a third party is liable).

The Third Party Liability functional area consists of four (4) major processes:

1) TPL policy information is maintained through processing adds, updates or deletes from various external entities.

2) Case tracking in an effort to recover monies on Medicaid paid claims where other entities are liable. Cases may include: Estate Recovery, Accident/Trauma, and Patient Liability for Nursing Homes.

3) TPL reports are used in the maintenance of TPL information. The report data is extracted from the Beneficiary, Reference, Claims, Provider, and TPL Tables.

4) TPL Letters are sent to various entities regarding TPL coverage. These include county offices, beneficiaries, carriers, policyholders, employers and providers seeking information regarding third party coverage or information regarding monies owed to the Bureau because of Post Pay Billings. Letter details may be found in the interChange Project Work Book (PWB).

The Third Party Liability function maintains the following logical data groupings:

TPL Resource information about other insurance information for the recipients;

Carrier information about other insurance companies that may have issued policies which cover recipients;

Employee information about policyholder employers;

Casualty Case information regarding potential payments to be recovered due to an accident or trauma; and

TPL Coverage information concerning the criteria used to determine if a service is covered by the Third Party Resource.

A.3.12.2 <u>TPL Contractor Requirements:</u>

A.3.12.2.1 Support a facility to display accumulated TPL recoveries and receivable amounts within user defined date ranges.

A.3.12.2.2 Track TPL recoveries, receivables, recoupments, and cost avoidance. Report monthly, quarterly and annually with a breakdown by commercial insurance and Medicare.

A.3.12.2.3 Maintain current and historical third party liability enrollee data.

A.3.12.2.4 Maintain current and historical third-party carrier information.

A.3.12.2.5 Maintain functionality to update enrollee TPL data and include update date, who made the update, and reason for the update.

A.3.12.2.6 Design, maintain, and support edits for inputs of enrollee demographic and TPL information to ensure consistency and validity of information received through online data entry or systematic data load, generating audit trails of changes with online access and/or error reports. The edits shall allow for the data to be rejected or input and reported.

A.3.12.2.7 Provide data and functional TPL processing requirements defined in Tennessee, State and federal Medicaid law, policy, and regulation to pass certification.

A.3.12.2.8 Maintain functionality to provide online inquiry capability to enrollee TPL and paid claim/encounter information to authorized parties.

A.3.12.2.9 Maintain functionality to provide TPL information to the appropriate Bureau business units and external Bureau entities, as directed by the Bureau.

A.3.12.2.10 Maintain functionality to provide the ability to accept, update, and exchange TPL data from various external files and information sources in defined data formats.

A.3.12.2.11 Develop and maintain edits to ensure that claims/encounters are identified where TPL exists.

A.3.12.2.12 Develop and maintain functionality to pend a claim for review or deny a claim when the claim fails TPL edit(s).

A.3.12.2.13 Develop and maintain functionality to auto deny claims when TPL resources are indicated on the TCMIS, but no TPL resources are indicated on the claim form, and no attachments such as insurance statements are submitted with the claims.

A.3.12.2.14 Develop and maintain functionality to allow the Bureau to respond to the provider claim denials and provide appropriate other insurance billing entity information.

A.3.12.2.15 Produce enrollee history profiles and copies of paid claims/encounters to assist in various collection activities and administrative processes.

A.3.12.2.16 Develop and maintain functionality to edit claims/encounters for trauma, accident, and casualty-related services, and produce reports, as needed.

A.3.12.2.17 Produce all required Bureau and federal TPL reports.

A.3.12.2.18 Provide functionality to produce billing forms in formats specified by the Bureau.

A.3.12.2.19 Provide training to the Bureau personnel in the use of the TPL capabilities of the TCMIS.

A.3.12.2.20 Accurately exchange TPL information with external agencies according to schedule.

A.3.12.2.21 Generate enrollee claims/encounter history listing within twenty-four (24) hours of request.

A.3.12.2.22 Provide copies of electronic claims/encounters to the Bureau within one (1) business day of request.

A.3.12.2.23 Maintain functionality to accurately record and maintain TPL information as required by the Bureau.

A.3.12.2.24 The Contractor shall be responsible for the following specific operational activities related to the processing of TPL processing:

A.3.12.2.24.1 Produce questionnaires on Estate and Casualty cases when recovery is not reflected, based on diagnosis code logic to generate with a limit set by the Bureau;

A.3.12.2.24.2 Develop and maintain edits to allow insurance claim processes that shall allow billing of UBs and HIC claims to insurance carriers;

A.3.12.2.24.3 Maintain the 270/271 Data Exchange process and put in place or update trading partner agreements with the Bureau's TPL contractor;

A.3.12.2.24.4 Assign staff to post recoveries from the providers so that TPL receipts are reflected as adjustment to claims; and

A.3.12.2.24.5 Maintain on-screen production of claims paid and the amount paid in the Case Tracking window of the TCMIS,

A.3.12.2.25 Contractor personnel shall post checks as they are received for provider refunds for overpayments (because of TPL), as well as Long Term Care insurance payments. Estimated volume of checks received shall be thirty (30) per day.

A.3.12.2.26 Maintain the TPL component of the TCMIS, including improvements/enhancements as they are implemented.

A.3.12.2.27 Provide the Bureau with online access and update all TPL components and system files, as needed by the Bureau.

A.3.12.2.28 Receive or provide files to the Bureau's TPL data match contractors for data exchanges with insurance carriers and governmental agencies for use in recoveries and utilization review. Perform those data exchanges according to schedule, with files to be provided as identified by the Bureau.

A.3.12.2.29 Develop and provide automated interfacing capabilities with external entities pertaining to the processing of third-party liability information.

A.3.12.2.30 Maintain functionality to capture and report all TPL data as needed by the Bureau.

A.3.12.2.31 Update system and operations documentation when system changes are made.

A.3.12.2.32 Maintain the capability for the TPL system to meet the federal requirements for MMIS certification. Provide the capability to maintain online access and update capability to a single consolidated Financial Accounting system that provides for posting the details of checks received for TPL and any other cash receipts received by the Bureau. The TPL Resource File data shall be verified to be one hundred percent (100%) accurate and shall interface with the Financial Accounting system.

A.3.12.2.33 Develop and maintain functionality to process files received from a collection agency and reverse claims that have been recouped.

A.3.12.2.34 For certification, ensure that the system is capable of storage and retrieval of

required TPL information.

A.3.12.2.35 Maintain functionality to ensure that the system correctly applies appropriate settlement payments to claims.

A.3.12.2.36 Develop and maintain a cash receipts process to assign a cash control number to all cash receipts, image all cash receipts indexed by cash control number, and allow tracking of funds as posted by cash control number.

A.3.12.2.37 Provide dedicated onsite Medicaid knowledgeable staff with specific knowledge of TPL and federal regulations to perform TPL maintenance and modification work requests. This staff shall become knowledgeable of the requirements specific to the Bureau and the TennCare TPL program.

A.3.12.2.38 Modify and maintain the TPL Case Tracking capabilities of the TCMIS, as directed by the Bureau through the Change Management process.

A.3.12.2.39 Generate TPL data to MCCs on a schedule defined by the Bureau.

A.3.12.2.40 Maintain Case Tracking capabilities in the TCMIS for Estate/Casualty Case development.

A.3.12.2.41 Assess the entire interchange TPL system and review with Bureau TPL unit to identify any possible changes or enhancements.

A.3.12.3 <u>Modification of Functionalities Requirements:</u>

The following requirements are functionalities that shall be developed and implemented by the Contractor after Bureau approval.

A.3.12.3.1 Develop and maintain functionality to receive, validate, and maintain complete online insurance information on all enrollees, including all levels of Medicare coverage and coverage dates, insurance carrier data, employer data, policyholder data, service types covered and dates.

A.3.12.3.1.1 Develop and maintain functionality to produce ad hoc reports on all TPL data and activity maintained on the TCMIS;

A.3.12.3.1.2 Develop a cash control file to allow posting of cash receipts to reflect reduction as posting occurs;

A.3.12.3.1.3 Develop the A/R system to allow TPL accounts receivable to reflect reductions to accounts online as TPL recoupments occur;

A.3.12.3.1.4 Develop a Billing File to allow upload from the TPL contractor and the contractor’s bills; and

A.3.12.3.1.5 Develop a process to post receipts from the cash control file to the Billing File and have the Billing File update claims history file.

A.3.12.4 TPL Inputs and Outputs

External Files

Below is a table that contains a list of all Third Party Liability Subsystem External (Input and Output) Files, as well as who sends or receives the file and the frequency. The Contractor shall ensure continuity of these file processes.

TPL Interface	Entity/ Vendor	Input/ Output	Freq	Media	Info/Description	File Layout
ACCENT Transactions	DHS	Input	Weekly	File	ACCENT TPL - Weekly	ACCENT Weekly TPL
Carrier Roster Request File	Carriers	Input	On Request	File	Request for Carrier Roster – On Request	Carrier Roster Request File
DEERS Recipient File	DOD	Output	Annually	Cartridge	Department of Defense – Annually	270 Eligibility Request
DEERS Response File	DOD	Input	Annually	Cartridge	Department of Defense – Annually	271 Eligibility Response
Department of Personnel	State	Input	Bi-Annual (Jan/July)	Cartridge	Department of Personnel – Bi-Annual	Department of Personnel File
Estate Recovery Extract File	DHS	Output	Monthly	File	Estate Recovery Extract – Monthly	DHS Estate Recovery Extract File
Estate Recovery Not Found File	DHS	Input	Monthly	File	Estate Recovery Not Found File – Monthly	DHS Estate Recovery Not Found File
Estate Recovery Surviving Spouse File	DHS	Input	Monthly	File	Estate Recovery Surviving Spouse File - Monthly	DHS Estate Recovery Surviving Spouse File
Estate Recovery Matched File	DHS	Input	Monthly	File	Estate Recovery Matched File – Monthly	DHS Estate Recovery Matched File
EDB Request File	CMS	Output	Monthly	Cartridge	CMS - Monthly	EDB Request File
EDB Response File	CMS	Input	Monthly	Cartridge	Medicare Eligibility Data Base	EDB Response File
Employer File	PIU	Input	On Request	File	Employers - On Request	Employer File
Insurance Carriers File - 270	Carriers	Output	On Request	EDI	Carriers – Daily	270 Eligibility Request

TPL Interface	Entity/ Vendor	Input/ Output	Freq	Media	Info/Description	File Layout
Insurance Carriers File - 271	Carriers	Input	On Request	EDI	Carriers – Daily	271 Eligibility Response
IV-D Request File	DHS	Output	Quarterly	File	DHS – Quarterly	IV-D Request File
IV-D Response File	DHS	Input	Quarterly	File	DHS – Quarterly	IV-D File
MCC Carrier File	MCC	Output	Monthly	EDI	MCC – Monthly	MCC Carrier File
MCC Response File	MCC	Input	Monthly	EDI	MCC – Monthly	MCC TPL File
MCC Resource File	MCC	Output	Monthly	EDI	MCC – Monthly	MCC TPL File
PARIS Request File	DHS	Output	Quarterly(Feb/ May/Aug/Nov)	File	PARIS output file	PARIS State Output File
PARIS Response File	DHS	Input	Quarterly(Feb/May/ Aug/Nov)	File	PARIS input file	PARIS State Input File
SHP/TIS File	State	Input	Monthly	Cartridge	State - Monthly	SHP TIS File
SSA TPL Response File	DHS	Input	Daily	Cartridge	SSA TPL resource file	SSA TPL File
State Prison Warm Body File	DOC	Input	Apr/Aug/Dec	File	Department Of Correction	State Prison Warm Body File
TPL Contractor Carrier	TPL Contractor	Output	Weekly	EDI	TPL Contractor - Weekly	MCC Carrier File
TPL Contractor TPL Coverage	TPL Contractor	Output	Weekly	EDI	TPL Contractor - Weekly	TPL File
TPL Contractor Response File	TPL Contractor	Input	Weekly	EDI	TPL Contractor - Weekly	TPL File
TPL County Jail Warm Body File	DOC	Input	Apr/Aug/Dec	File	Department of Correction	TPL County Jail Warm Body File

A.3.12.5 TPL Bureau Responsibilities:

A.3.12.5.1 Review and approve Contractor processing for TPL data exchanges.

A.3.12.5.2 Develop policies and procedures for TPL data exchanges.

A.3.12.5.3 Access federal TPL requirements and ensure compliance through the Contractor.

A.3.12.5.4 Provide written specifications, and approve procedural changes, for the TPL functional areas.

A.3.12.5.5 Negotiate data exchange arrangements with insurance carriers and governmental agencies, as required.

A.3.13 Reference

A.3.13.1 Reference Data Maintenance

The Reference Data Maintenance business area is responsible for maintaining Reference files that are a repository of current and historical pricing, prepayment utilization review, prior authorization, and code validation information, which is used to process fee-for-service (FFS) claims and encounter transactions. The Reference Data Maintenance business area collects, maintains and updates the information used to define and enforce TennCare policies and/or rules related to covered services, prior authorization requirements, medical policy, service restrictions, and reimbursement. Other business areas (such as Claims/Encounter Processing, Prior Authorization, Third Party Resources, and SUR) access the Reference files during system processing to retrieve stored data used to make pricing determinations, post edits, or secure other Reference data. The TCMIS provides the capability for entry directly into the TCMIS Reference files, making the information immediately available for claims and encounter processing.

The Reference Data Maintenance function maintains the following logical data groupings:

1) Benefit Package identifies the set of benefits a recipient can be eligible to receive and providers may bill according to Bureau policy and/or rules.

2) Diagnosis utilizes the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) coding system.

3) DRG data set utilizes the Diagnosis Related Group (DRG) codes used to group patients according to diagnosis, type of treatment, age, and other relevant criteria.

4) Drug is a data set containing eleven (11) digit National Drug Codes (NDC) and related drug information.

5) Edit / Audit Criteria are used to enforce Bureau policy in adjudicating claims and encounters.

6) ICD-9-CM procedure codes contain International Classification of Diseases, Ninth Revision, Clinical Modification procedure codes used for inpatient hospital billing.

7) Modifier contains codes used to further describe and qualify services provided.

8) Procedure contains CMS Healthcare Common Procedure Coding System (HCPCS) procedure codes, Common Procedure Terminology, version four (CPT-4) procedure codes and American Dental Association (ADA) procedure codes.

9) Revenue Codes are used in processing claims for hospital inpatient and outpatient services.

10) Code Tables are used in the interChange system.

A.3.13.1.1 Benefit Package

The Benefit Package data grouping contains program codes identifying various programs that may be active for an eligible recipient during a particular eligibility period. A recipient may be assigned to more than one (1) benefit package at a time.

Although the tables that are used to maintain benefit package information are maintained in the reference subsystem area, Benefit Package is a system wide functionality and solution. (Refer to the TennCare Benefit Package Definition in the Benefit Package subsystem area in the PWB to view how Benefit Packages are defined and used in the iC TCMIS)

The Benefit Package data structure contained within the interChange system is used to define how benefit packages are maintained throughout the system.

A.3.13.1.2 Diagnosis

Diagnosis codes are used to identify services and/or items provided by a provider or healthcare facility. The diagnosis coding structure used is the International Classification of Disease - Ninth Revision, Clinical Modification (ICD-9-CM). ICD-9-CM coding is a national coding method that enables providers to document the medical condition, symptom or complaint, which is the basis for rendering a specific service(s). This coding system consists of three (3) to five (5) digit numeric or alphanumeric codes.

The diagnosis data set is utilized in claims processing to support relationship editing between diagnosis code and claim information. Examples of diagnosis relationship editing include recipient age, sex, and procedure compatibility. The diagnosis structure contained within the interChange system is used to define how diagnosis codes are maintained throughout the system.

A.3.13.1.3 DRG

Diagnosis Related Groups (DRGs) represent an inpatient classification scheme designed to categorize patients who are medically related to diagnoses and treatment, and are statistically similar in their lengths of stay in the claims processing system. DRGs are three (3) digit numeric codes used as the basis for the analysis and prospective payment of inpatient hospital care.

A.3.13.1.4 NDC

The Drug data grouping contains data defining a drug, which includes the drug's National Drug Code (NDC), manufacturer, strength, dosage form, and package size. The majority of the data is received from a drug information provider such as First Data Bank (FDB). The

drug data set is used in claims processing for editing and pricing pharmacy claims. The drug data set also supports the Drug Rebate functions of the system.

A.3.13.1.5 Edit/Audit Criteria

The Edit/Audit Criteria processing function ensures that claim records are processed in accordance with Bureau policy. The edit/audit data grouping supports the application of non-history related edits and history-related audits. Claims are screened against data in the system such as recipient, provider, reference (i.e., procedure, diagnosis, drug), and adjudicated claims. Those claims that do not satisfy program or processing requirements are handled according to Bureau policy. The Edit/Audit data grouping has been developed to support the application of Bureau policy in the claims system.

A.3.13.1.6 ICD-9-CM

ICD-9-CM Procedure codes are used to identify surgical or diagnostic services. The International Classification of Disease - Ninth Revision, Clinical Modification (ICD-9-CM) coding structure is a national coding method that enables providers to bill procedures on inpatient claims. This coding system consists of four (4) digit numeric or alphanumeric codes.

A.3.13.1.7 Modifiers

Modifiers are used in combination with procedure codes to further describe and qualify services billed on a claim. A modifier is assigned a modifier type. Modifier types are used to describe the way a modifier is used in claims processing.

A.3.13.1.8 Procedure Codes

Procedure codes are used to identify the services provided. Procedure codes are designed around a five (5) character coding format defined by the Centers for Medicare and Medicaid Services (CMS) called the Healthcare Common Procedure Coding System (HCPCS). These procedures are commonly known as HCPCS procedures. HCPCS procedures provide health-care providers and third party payers a common coding structure for determining claims adjudication.

The procedure data set consists of HCPCS codes from CMS, and codes from the Common Procedure Terminology, 4th Revision (CPT-4) manual.

The different types of procedure codes are defined as follows:

A.3.13.1.8.1HCPCS Codes

Defined by the Centers for Medicare and Medicaid Services (CMS).

HCPCS procedure codes are all alphanumeric consisting of a single alpha character (A – V) followed by four (4) numeric digits.

Updated annually.

A.3.13.1.8.2CPT-4 Codes

Defined by the American Medical Association's (AMA) Physicians' Common Procedure Terminology, 4th revision (CPT-4).

CPT-4 codes are all numeric and consist of five (5) digits.

Updated annually.

A.3.13.1.8.3Dental Codes

Defined by the American Dental Association (ADA) Current Dental Terminology, fourth edition (CDT-4).

CDT-4 codes are all numeric and consist of five (5) digits alpha-numeric codes comprising the D series.

Updated annually.

A.3.13.1.9 Procedure Data

The procedure data set supports claims processing by providing pricing methodology, price, effective dates, and restrictions related to policy or validity.

Examples of restrictions enforced by the procedure data are:

Prior Authorization and/or Medical Review required

Age and sex

Allowable provider type and specialty

Place of service or tooth number

Documentation requirements

Diagnosis required and compatibility

A.3.13.1.10 Revenue Codes

Revenue codes are three (3) digit numeric codes that identify specific accommodation or ancillary services. Revenue codes are used in processing claims for hospital inpatient and outpatient services.

A.3.13.1.11 Additional References

The Reference Subsystem area maintains many various code tables that are used throughout the system. Some examples of code tables maintained within the Reference Subsystem area are as follows: Accident Type, Admit Source, County, Occurrence, Patient Status, Race, Region, State, tooth number, surface, quadrant, type of bill, value.

A.3.13.2 Reference Contractor Requirements:

A.3.13.2.1 Maintain current Federal Poverty Level (FPL) and historical FPL tables with effective dates.

A.3.13.2.2 Accept and maintain laboratory fee schedules (to support Clinical Laboratory Improvement Amendments (CLIA) certification requirements).

A.3.13.2.3 Maintain edit criteria including any edit dispositions.

A.3.13.2.4 Maintain error and remittance text information and explanation of benefits (EOB).

A.3.13.2.5 Maintain the Bureau-specific codes (including, but not limited to, modifiers) online for historical purposes.

A.3.13.2.6 Maintain capability to accept and maintain the complete data set prescribed by Part 11 of the State Medicaid Manual.

A.3.13.2.7 Maintain a procedure data set that contains HCPCS codes for medical, surgical, dental, and other professional services, contains HCPCS modifiers, and contains ADA dental codes.

A.3.13.2.8 Maintain a diagnosis data set of medical diagnoses and surgical codes that can maintain relationship edits for each diagnosis code and/or surgical code.

A.3.13.2.9 Maintain a drug data set and process updates from the State's contracted Pharmacy Benefits Manager.

A.3.13.2.10 Maintain rate schedules for processing claims.

A.3.13.2.11 Maintain current and historical MCC rate data sets for use in capitation processing, including capitation price segments with specific dates to allow for retroactive payments.

A.3.13.2.12 Maintain current and historical pricing data to be used in claims processing. The pricing segments are date specific.

A.3.13.2.13 Process online and batch updates to all Reference files.

A.3.13.2.14 Provide the capability and flexibility to identify and accommodate multiple reimbursement methodologies (e.g., case mix based payment structure for long term care facilities.)

A.3.13.2.15 Maintain the functionality to define and change a range of provider types and payment arrangements linked to specific waiver services and program entities (e.g., HCBS providers based on the program entity, waiver, provider type, member eligibility category and contractual terms of the agreement) facilitating the functionality to pay a different fee to the same provider for the same service based on a waiver category, program entity or member status. The payment arrangements include fee-for-service, capitation, unit pricing, risk sharing, and other TennCare-defined mechanisms.

A.3.13.2.16 Maintain online access to all Reference files with inquiry by approved users, depending on the file being accessed.

A.3.13.2.17 Maintain the Edit Criteria table to provide a user controlled method of establishing service frequency, quantity limitations, and service conflicts for selected procedures and diagnoses.

A.3.13.2.18 Maintain a user controlled Claim Edit Disposition data set with disposition information for each edit used in claims/encounter processing, including the

disposition by any submission medium within claim type, including capitation payment and premium payment adjustment reason codes. For each edit error, maintain the description of the error, the related remittance Explanation of Payment (EOP) and EOB codes, and edit recycle times and frequency, with online update capability for all parameters and information.

A.3.13.2.19 Maintain all online audit trails of all changes made to Reference files. The audit trails shall show the changed data element, before-and-after images of the change, the date of the change, and the source of the change or the individual who made the change.

A.3.13.2.20 Generate reports to support the Reference Data Maintenance function, as directed by the Bureau.

A.3.13.2.21 Maintain up to seventy-two (72) months of pricing history by date segment.

A.3.13.2.22 Support multiple benefit schedules, as defined by the Bureau.

A.3.13.2.23 Support multiple benefit plans and associated benefit limits, as defined by the Bureau.

A.3.13.2.24 Maintain Reference system as defined in federal, State, and Certification requirements.

A.3.13.2.25 Operate the interChange Reference Data Maintenance functions. This includes processing updates from external interfaces (e.g., First Data Bank, CIGNA, MCCs, HMS, CMS, and Ingenix).

A.3.13.2.26 Provide current and historical information to be used in claims processing.

A.3.13.2.27 Maintain controls and audit trails to ensure that only the most appropriate Reference data is used in claims processing.

A.3.13.2.28 Process automated files or manual updates to update fee schedules and other Reference data.

A.3.13.2.29 Process retroactive rate changes and Medicaid policy changes as they relate to rate appeals, medical procedures, and limitations, as defined by the Bureau.

A.3.13.2.30 Provide authorized personnel with online inquiry and update capabilities to all Reference data.

A.3.13.2.31 Maintain the Reference data that supports claims edits and pricing logic in accordance with Bureau policies and/or rules.

A.3.13.2.32 Maintain edits to address the policy changes or additions for Bureau review. Any proposed edits shall be documented and presented in a manner easily understood by non-technical users.

A.3.13.2.33 Provide technical assistance to the Bureau in developing new edits required to respond to State or federal audit findings, quality assurance findings, and other Bureau areas of concern, including, but not limited to providing analysis of options and recommendations for the most effective means of implementing the desired solution.

A.3.13.2.34 Perform mass updates to the Reference data, as specified by the Bureau.

A.3.13.2.35 Ensure that only authorized personnel are able to submit changes or make changes online to the Reference data according to established security and validation procedures.

A.3.13.2.36 Provide on-going training to the Bureau staff in the use of the Reference data functions, as requested by the Bureau.

A.3.13.2.37 Update pricing information and other Reference data in accordance with the Bureau's procedures.

A.3.13.2.38 Submit status reports on a schedule defined by the Bureau. that describes changes occurring in the system, including, but not limited to, the reason for the change.

A.3.13.2.39 Ensure procedures and modifiers are correctly identified, linked to appropriate codes so that claims price correctly and edits post according to specifications.

A.3.13.2.40 Provide definition for all modifiers, including how the system processes the modifiers, to all relevant Contractor and Bureau staff.

A.3.13.2.41 Purge inactive records on a schedule to be defined by the Bureau.

A.3.13.2.42 Perform updates to drug pricing and rebate files (e.g., federal Maximum Allowable Cost (MAC), Internal Revenue Service (IRS)) in accordance with federal effective dates, as directed by the Bureau.

A.3.13.2.43 Operate the Reference component of the TCMIS, including improvements/enhancements as they are implemented.

A.3.13.2.44 Maintain updates to the drug file/database online with Bureau changes relating to pharmacy program policy and pricing.

A.3.13.2.45 Update Reference files/tables online with changes relating to Reference policy and pricing.

A.3.13.2.46 Support all Reference functions, files, and data elements necessary to meet the requirements in this Contract and as specified by the Bureau.

A.3.13.2.47 Maintain all Reference files/database tables and ensure that only the most applicable, up-to-date information is used in claims processing.

A.3.13.2.48 Maintain current and historical Reference data in Reference files/tables that support claims edits, audits, and pricing logic in accordance with Bureau policies and/or rules.

A.3.13.2.49 Maintain functionality to provide the Bureau with online inquiry capabilities, based on appropriate security, to all Reference files.

A.3.13.2.50 Perform Reference file/database updates in accordance with Bureau policy and as directed by the Bureau.

A.3.13.2.51 Provide audit trails for Reference file changes, including rates, codes, edit/audit changes, to show before-and-after images for transactions from the previous day.

A.3.13.2.52 Edit and validate all Reference file updates to ensure the integrity of data.

A.3.13.2.53 Generate and submit to the Bureau all reports created by the Reference Data Maintenance function, in accordance with the schedule determined by the Bureau.

A.3.13.2.54 Utilize the coding systems selected by the Bureau for all Reference files/database tables.

A.3.13.2.55 Establish relationships between providers and each procedure or service for which they are authorized to bill and be paid. This relationship shall be used to process all claims.

A.3.13.2.56 Obtain, and update the diagnosis file/database with diagnosis data, on a schedule defined by the Bureau.

A.3.13.2.57 Provide analysis of HCPCS code updates as needed by the Bureau.

A.3.13.2.58 Process the HCPCS update file and apply updates to the appropriate Reference files/database tables in accordance with Bureau policies and/or rules.

A.3.13.2.59 Provide copies of the Usual and Customary Charge data set and fee schedules to the Bureau upon request.

A.3.13.2.60 Provide ability to obtain and store online a current copy of the Resource-Based Relative Value Scale (RBRVS) data set, or similar data set as identified by the Bureau.

A.3.13.2.61 Provide training to the Bureau in the use of the Reference functions initially and on an ongoing basis.

A.3.13.2.62 Consult with Bureau staff regarding medical policy, pricing, and file maintenance and provide assistance when needed.

A.3.13.2.63 Identify, and advise the Bureau of proposed changes to edits and audits to

enhance processing and efficiency.

A.3.13.2.64 Maintain, and coordinate with the Bureau, updates to the institutional rates on the Reference File/Database.

A.3.13.2.65 Update system and operations documentation when subsystem changes are made.

A.3.13.2.66 Make written recommendations on any area in which the Contractor or the Bureau thinks improvements can be made.

A.3.13.2.67 Receive all changes to and requests for listings of the procedure, diagnosis, and formulary files.

A.3.13.2.68 Maintain functionality to produce reasonable charge listings by practitioner and by region.

A.3.13.2.69 Transfer older records from the current master to the history files. Maintain functionality to generate summaries of history file transfers.

A.3.13.2.70 Maintain functionality to edit all transactions.

A.3.13.2.71 Produce a listing of all erroneous input.

A.3.13.2.72 Use error-free inputs to update the files and generate report files.

A.3.13.2.73 Produce an audit trail of all file changes.

A.3.13.2.74 Maintain functionality to extract practitioner charge data for changes in charge profiles.

A.3.13.2.75 Maintain functionality to analyze practitioner charge data for changes in charge profiles.

A.3.13.2.76 Maintain functionality to produce records of changed charge profiles.

A.3.13.2.77 Update, as necessary, the usual and customary charge file.

A.3.13.2.78 The Contractor shall maintain and regularly update the TCMIS Reference files which include, but are not limited to:

A.3.13.2.78.1 American Dental Association (ADA) procedure codes;

A.3.13.2.78.2 International Classification of Diagnosis, Ninth Edition, Clinical Modification (ICD-9–CM) procedure and diagnosis codes;

A.3.13.2.78.3 Revenue codes;

A.3.13.2.78.4 Drug information;

A.3.13.2.78.5 Drug rebate information;

A.3.13.2.78.6 Medical information (e.g., modifiers);

A.3.13.2.78.7 Lab fee schedules;

A.3.13.2.78.8 Edit criteria;

A.3.13.2.78.9 Edit dispositions (pay, pend, claim correction, and deny);

A.3.13.2.78.10 Error and remittance text information and explanation of benefits (EOBs);

A.3.13.2.78.11 Pricing for CPT-4 and HCPCS procedure codes, National Drug Codes (NDC), and Bureau of TennCare specific service codes;

A.3.13.2.78.12 Pricing for provider rates, UCR, prevailing fee by region and specialty, and maximum fee;

A.3.13.2.78.13 Periodicity schedules for EPSDT processing;

A.3.13.2.78.14 Ambulatory Surgical Center Pricing;

A.3.13.2.78.15 Co-pay criteria; and

A.3.13.2.78.16 Grouping information (e.g., National Drug Code (NDC), Global Clearing Network (GCN), Health Insurance Contract Language (HICL), Diagnosis, Revenue).

A.3.13.3 Modification of Functionalities Requirements:

The following requirements are functionalities that shall be developed and implemented by the Contractor after Bureau approval.

A.3.13.3.1 Maintain flexibility in the diagnosis code file to accommodate expanded diagnosis codes and/or new coding structure with the potential implementation of ICD-10-CM or other required coding changes.

A.3.13.4 Reference Inputs and Outputs

This table lists information about specific files that are used in TCMIS Reference processing. The Contractor shall ensure continuity of these file processes.

Reference Interface	Entity/ Vendor	Input/ Output	Freq	Destination/Info/Description
Alpha-Numeric HCPCS File	SE in charge of Reference downloads from CMS website	Input	Annually	Healthcare Common Procedure Coding System (HCPCS) Files – from CMS repository. The HCPCS file contains both the CPT-4 and alpha-numeric procedure and modifier codes.
Medicare Fee Schedule (DME - durable medical equipment)	CIGNA	Input	Annually	CIGNA provides Medicare pricing updates. This file contains pricing updates for DME services.

Reference Interface	Entity/ Vendor	Input/ Output	Freq	Destination/Info/Description
Medicare Fee Schedule (HPH - hospice phys services)	CIGNA	Input	Annually	CIGNA provides Medicare pricing updates. This file contains pricing updates for hospice services.
Medicare Fee Schedule (LAB - laboratory)	CIGNA	Input	Annually	CIGNA provides Medicare pricing updates. This file contains pricing updates for laboratory procedures.
Medicare Fee Schedule (ODX - other diagnostic services)	CIGNA	Input	Annually	CIGNA provides Medicare pricing updates. This file contains pricing updates for other diagnostic services.
Medicare Fee Schedule (OXY - oxygen)	CIGNA	Input	Annually	CIGNA provides Medicare pricing updates. This file contains pricing updates for oxygen related services.
Medicare Fee Schedule (P/O - prosthetic and orthotics)	CIGNA	Input	Annually	CIGNA provides Medicare pricing updates. This file contains pricing updates for prosthetic and orthotic services.
Medicare Fee Schedule (RAD - radiology)	CIGNA	Input	Annually	CIGNA provides Medicare pricing updates. This file contains pricing updates for radiology services.
Medicare Fee Schedule (PRF - portable radiology)	CIGNA	Input	Annually	CIGNA provides Medicare pricing updates. This file contains pricing updates for portable radiology services.
Medicare Fee Schedule (CNA - certified nurse anesthetist)	CIGNA	Input	Annually	CIGNA provides Medicare pricing updates. This file contains pricing updates for certified nurse anesthetist services.
Medicare Fee Schedule (AMB - ambulance)	CIGNA	Input	Annually	CIGNA provides Medicare pricing updates. This file contains pricing updates for ambulance services.
Medicare Fee Schedule (NRS - nurse practitioners)	CIGNA	Input	Annually	CIGNA provides Medicare pricing updates. This file contains pricing updates for nurse practitioner services.
Medicare Fee Schedule (PAS - physician assistant)	CIGNA	Input	Annually	CIGNA provides Medicare pricing updates. This file contains pricing updates for physician assistant services.

Reference Interface	Entity/ Vendor	Input/ Output	Freq	Destination/Info/Description
Medicare Fee Schedule (INJ - injections)	CIGNA	Input	Annually	CIGNA provides Medicare pricing updates. This file contains pricing updates for injection procedures.
Medicare Fee Schedule (all other procedure codes)	TCMIS will download from CMS website and send to Facilities Manager	Input	Annually	TennCare will provide pricing data for services not contained in the CIGNA files.
ICD-9 Diagnosis update file	St Anthony's	Input	Annually	This file contains updates for the ICD-9 diagnosis code set.
ICD-9 Procedure update file	St Anthony's	Input	Annually	This file contains updates for the ICD-9 procedure code set.
First Data Bank (FDB) Drug File	First Data Bank	Input	Weekly	This file contains update information needed to maintain Drug related data.

A.3.13.5 Reference Bureau Responsibilities:

A.3.13.5.1 Determine and interpret policy and administrative rules related to covered services, allowed charges, and changes in codes.

A.3.13.5.2 Establish and approve all policies governing procedure code, revenue code, or rate code usage and new medical procedures.

A.3.13.5.3 Establish all rates, fees, and other pricing instructions, and authorize all pricing updates.

A.3.13.5.4 Identify procedures that require prior authorization/prior approval and all services that are covered under the TennCare program and waiver programs.

A.3.13.5.5 Perform online updates to Reference files.

A.3.13.5.6 Approve any additions, corrections, changes, or deletions to Reference data elements.

A.3.13.5.7 Provide the operational and policy parameters used by the Contractor to design or modify edits.

A.3.13.5.8 Specify the benefit limitation and service conflict criteria to be applied during claims processing.

A.3.13.5.9 Authorize any revisions to the edit hierarchy.

A.3.13.5.10 Review and approve all REOMB and RA messages to ensure clarity in interpretation.

A.3.13.5.11 Define alternate pricing methodologies to be implemented in the future.

A.3.13.5.12 Respond to inquiries from the Contractor regarding discrepancies in Reference data information.

A.3.13.5.13 Define and interpret for the Contractor the detailed policies and payment objectives related to the use of DRG pricing and any other reimbursement methodologies.

A.3.13.5.14 Validate Reference data integrity on an ongoing basis.

A.3.13.5.15 Request and approve mass updates (e.g., regular and irregular updates) to files as necessary.

A.3.13.5.16 Select or approve contractors providing Reference data updates to the TCMIS.

A.3.13.5.17 Forward copies of proposed policy changes or new policies to the Contractor.

A.3.14 Long Term Care Business Unit

The primary goal of the Long Term Care (LTC) Unit is to coordinate and improve the quality of services to TennCare enrollees. The LTC Unit monitors the quality of long-term care services and special waiver services provided to TennCare enrollees.

There are several Units within the Long Term Care Unit overseeing HCBS Waiver Programs.

The PACE program (limited to Hamilton County) has approximately two hundred (200) enrollees. A TennCare contractor is responsible for the management of this program.

The Claims Unit is responsible for monitoring provider claims payment, provider education (for claims processing and policy), voids/adjustments to payments, and technical assistance to nursing homes.

A Quality Monitoring (QM) Unit monitors the quality of care in waiver and institutional programs. The Department of Health conducts surveys and certifications of nursing home facilities and ICF/MRs. Long Term Care receives survey findings and enforcement recommendations for Medicaid only facilities when civil monetary penalties are assessed. Currently, these are received and processed by the Claims Unit Manager, but this function will eventually move to the QM Unit.

A.3.14.1 Prior Authorization (Preadmission Evaluation)

The Division of Long Term Care (DLTC) processes thirty thousand to thirty-two thousand (30,000 to 32,000) Preadmission Evaluations (PAE) applications per year for individuals seeking Medicaid reimbursement of nursing home care, ICF/MR services, HCBS waiver programs, and PACE services.

A.3.14.2 LTC Appeals

A PAE (medical eligibility) appeal may occur for HCBS waivers, PACE, and nursing facility or ICF/MR applicants when the PAE is denied. For Nursing Facility applicants, a denial may result in a PASARR appeal if the denial was based on a PASARR finding, which indicated the need for special services. There may also be service appeals and disenrollment appeals for the HCBS waiver population.

A.3.14.3 LTC Contractor Requirements (requirements shall be confirmed through validation with the Bureau as part of requirements analysis.):

A.3.14.3.1 Support processing of PAEs, HCBS, and LTC authorizations through receipt, distribution, decision, and response processes.

A.3.14.3.2 Support functionality to provide access to appeals information for associated TennCare departments and units as well as authorized external entities.

A.3.14.3.3 Maintain the functionality to accept LTC claims (TAD-like claims) through the web portal.

A.3.14.3.4 Maintain functionality to generate standard notices and correspondence to responsible parties within established deadlines.

A.3.14.3.5 Maintain functionality to process capitated payments for PACE enrollees according to the admit date, or as specified by the Bureau.

A.3.14.3.6 Maintain process to assign unique provider numbers for LTC providers.

A.3.14.3.7 Maintain functionality to accept, store and retrieve PAE data.

A.3.14.3.8 Maintain the system functionality to process various payment methodologies for administering payments to HCBS providers. Payment arrangements include fee-for-service, capitation, unit pricing, risk sharing, encounter rates and other Bureau defined mechanisms.

A.3.14.3.9 Maintain functionality to accept claims directly from waiver service providers.

A.3.14.3.10 Maintain functionality to accept claims with reassignment of payment to the HCBS programs.

A.3.14.3.11 Maintain functionality to track and report on MCO/BHO encounters of LTC enrollees.

A.3.14.3.12 Maintain functionality to accept all claims from all provider types electronically.

A.3.14.3.13 Develop the Bureau's ability to track and report on PAE status and produce an aging report for prioritization (work flow management), in accordance with the Change Management Process.

A.3.14.3.14 Maintain the database to share waiver information between multiple State agencies, including data extracts and online queries.

A.3.14.3.15 To the extent that the parties agree to incorporate PAE automation support, Contractor will provide support and consultation to the Bureau using existing Contract resources in administering its electronic PAE capabilities.

A.3.14.3.16 Maintain functionality to accept, track and report Long-Term Care and waiver service appeals, to include, but not limited to:

A.3.14.3.16.1 Online access to appeals information;

A.3.14.3.16.2 Functionality to report status information;

A.3.14.3.16.3 Maintain Recognition Research Imaging (RRI) images of all appeals information;

A.3.14.3.16.4 Archive, and facilitate online viewing and retrieval of cases;

A.3.14.3.16.5 Support access of all electronic records of PAE entered and stored in the TCMIS;

A.3.14.3.16.6 Encounter/claims history relating to the appeal and track by enrollee all appeals filed with decisions made by staff and administrative law judges;

A.3.14.3.16.7 Support all "Alerts" of staff when an appeal deadline is approaching; and

A.3.14.3.16.8 Generate standard notices, appeal acknowledgement and decision notices to enrollee, enrollee's designee and the service provider.

A.3.14.3.17 Maintain TCMIS edits for inputs (PAE and TAD-like claims) to ensure consistency and validity of information received through online data entry.

A.3.14.3.18 Maintain system to process Preadmission Evaluation (PAE) approvals entered into the TCMIS by the Bureau on a real-time basis, and to edit Claims with associated PAE data.

A.3.14.3.19 Ensure that the mandated annual CMS-372 report is generated according to the scheduled date due.

A.3.14.3.20 Operate and maintain the Long Term Care tracking components of the interChange TCMIS for institutional and waiver programs.

A.3.14.3.21 Maintain a file/database of services provided to institutional and waiver program participants.

A.3.14.3.22 Maintain and provide online access to information available to the CMS, MHDD, OGC, PACE, nursing facilities and ICF/MR facilities, community providers, TCA, DHS, DMRS, the Pace provider, DHCF, the Comptroller of the Treasury, the State Patient Care Advocate, MCCs and other State Contractors.

A.3.14.3.23 Perform online eligibility changes to ensure appropriate processing of Long Term Care and waiver program claims.

A.3.14.3.24 Maintain process for assigning a unique claim reference number to every paper claim, void, and adjustment within one (1) business day of the date received. Attachments shall receive the same unique number as the document to which it is attached.

A.3.14.3.25 Maintain function to image claims and any attachments. Process/archive every claim and attachment within one (1) business day of receipt.

A.3.14.3.26 Maintain data entry keying accuracy standards of ninety-nine percent (99%) for claims and other transactions.

A.3.14.3.27 Maintain capability to accept online real time submission of TAD-like claims and encounter data, via portal entry twenty-four (24) hours per day, seven (7) days per week.

A.3.14.3.28 Assign a unique claim reference number upon entry into the TCMIS interChange system.

A.3.14.3.29 Load claims submitted electronically to the claims engine within one (1) business day of receipt.

A.3.14.3.30 Process, edit, and adjudicate claims and encounters a minimum of five (5) times per week or as directed by the Bureau.

A.3.14.3.31 Correctly adjudicate ninety percent (90%) of all FFS claims within thirty (30) calendar days of receipt and one hundred percent (100%) of all FFS claims within sixty (60) days of receipt (pay, pend or deny.) Additionally, one hundred percent (100%) of clean claims that are received through EDI shall be processed within twenty-one (21) calendar days. One hundred percent (100%) of clean claims that are received on paper shall be processed within thirty (30) calendar days, or according to Bureau requirements.

A.3.14.3.32 Maintain the process to provide online notification to providers, within twenty-four (24) hours of transmission, regarding any transmission or claim data errors or acceptability for further processing. This includes HIPAA compliant response acknowledgements.

A.3.14.3.33 Ensure assignment of a unique claim reference to electronic media captured claims, voids, and adjustments within one (1) business day of the date received.

A.3.14.3.34 Return claims or attachments missing required or unreadable data within one (1) business day of receipt. Any attachments shall be returned with the claims. Instructions for the providers on how to correct and resubmit the returned claims shall be included when the claims are returned to the provider and tracked by an audit trail. All claims correspondence sent to and received from providers shall be imaged and associated with the provider's record. All correspondence shall

be stored and retrievable online upon authorized user demand.

A.3.14.3.35 Support the functionality to update claims data resubmitted by providers, within three (3) business days of receipt.

A.3.14.3.36 Support functionality to produce, reconcile, and submit balancing and control reports that reconcile all claims, including encounter claims, entered into the system to the batch processing cycle input and output counts. This process shall also apply to all claims, TAD-like claims, and encounter data accepted online real time. The reports shall be provided online and be made available as defined by the authorized user and include management level reports to account for all claims at all times. All reports shall also be made available through the web portal if requested by authorized users.

A.3.14.3.37 Generate and submit claims and encounter inventory and operations reports after each claims/encounter processing cycle.

A.3.14.3.38 Maintain functionality to update the claims and encounter entry files daily, or as received.

A.3.14.3.39 Provide retrieval of hard-copy claim documentation/correspondence image upon user request.

A.3.14.4 Modification of Functionalities Requirements:

The following requirements are functionalities that shall be developed and implemented by the Contractor after Bureau approval.

A.3.14.4.1 Support the process for LTC HCBS presumptively eligible recipients. This includes ensuring that the required data is retained to allow eligibility according to Bureau policies and/or rules in order to process LTC claims (e.g., compute appropriate eligibility dates of forty-five (45) days' eligibility and require PAE data).

A.3.14.5 LTC Bureau Responsibilities:

A.3.14.5.1 Notify the Contractor of any changes in federal or Bureau requirements affecting these programs.

A.3.14.5.2 Provide information to the Contractor about changes to Long Term Care and Waiver programs so that notices may be generated to enrollees and families or caregivers.

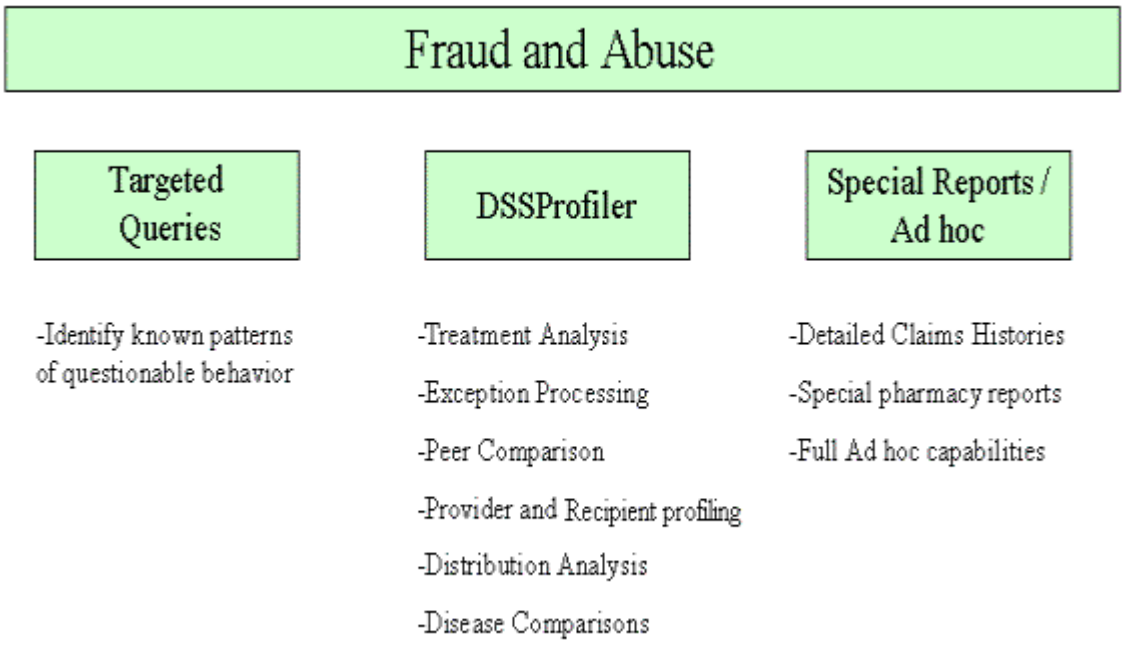
A.3.15 Program Integrity/Surveillance and Utilization Review (SUR)/Fraud and Abuse

The SUR functional area of the TCMIS is used to monitor both fee-for-service and encounter claims processed by the Bureau for fraud and abuse by providers and recipients. All

requirements of a SUR subsystem shall continue to be maintained and updated as required by the Bureau.

The interChange relational database provides Bureau policymakers, analysts, and other users with information to perform analysis, trending, monitoring, and managing of Medicaid data. The Fraud and Abuse/SUR subsystem encompasses three (3) components: Targeted Queries, DSSProfiler, and Ad Hoc reports.

The diagram below depicts the Fraud and Abuse components:



A.3.15.1 <u>SURS Contractor Requirements:</u>

A.3.15.1.1 Maintain data used in identifying and reporting potential or suspected fraud and abuse investigations. This includes TPL information from eligibility, claims, and encounter data.

A.3.15.1.2 Provide systems functionality to identify enrollees with other primary insurance. Also provide capabilities to manage private health insurance, Medicare, Medicaid, and other third party resources of TennCare enrollees to ensure that the Bureau is the payer of last resort.

A.3.15.1.3 Support automated processes to maximize cost-avoidance.

A.3.15.1.4 Maintain secure and fully controlled security levels and privileges, but flexible and

easily modified.

A.3.15.1.5 Maintain secure controlled access to provider enrollment, enrollee eligibility, and claims and encounter files from multiple locations.

A.3.15.1.6 Maintain functionality to associate/track all providers by a variety of methods such as provider name, group name, Medicare provider number, NPI, CLIA number, SSN, Drug Enforcement Agency (DEA) number, National Council for Prescription Drug Programs (NCPDP) number, Universal Provider Identification Number (UPIN), professional license number, or any other unique identifier.

A.3.15.1.7 Provide providers and enrollees multiple access paths to confidentially report possible fraud/abuse situations.

A.3.15.1.8 Provide alerts to appropriate agencies of suspected fraud/abuse situations.

A.3.15.1.9 Provide functionality to compare the TCMIS eligibility files for data validation matches with other external agencies to support SURS, Fraud and Abuse detection and TPL functions.

A.3.15.1.10 Provide inquiry capability to data loaded from external agency files.

A.3.15.1.11 Maintain and operate the SUR subsystem including future enhancements as per the Bureau's instructions.

A.3.15.1.12 Maintain the SUR subsystem according to federal MMIS General System Design (GSD) certification requirements and all Bureau requirements.

A.3.15.1.13 Maintain SURS selection criteria based on input prepared by the Bureau.

A.3.15.1.14 Produce and distribute SUR reports as required by the Bureau.

A.3.15.1.15 Support functionality to maintain data needed for delivery and utilization of medical care for SURS processes used to safeguard the quality of care and to guard against TennCare fraud or abuse, by either enrollees or providers for both fee-for-service and managed care.

A.3.15.1.16 Maintain a complete SURS user manual describing in detail the purpose and use of the SURS component of the TCMIS. The manual shall include the data elements used in the definitions and valid values for each element, along with the definition of the data element.

A.3.15.1.17 Update system and operations documentation when system changes are made.

A.3.15.1.18 Produce comprehensive statistical profiles of recipient utilization by peer group categories of services authorized under the Medicaid program.

A.3.15.1.19 Produce comprehensive statistical profiles of provider health care practices by peer groups for all categories of services authorized under the Medicaid

program.

A.3.15.1.20 Produce reports of averages and standard deviations which are computed to establish norms or exception criteria for each indicator in the statistical profiles.

A.3.15.1.21 Operate and maintain SURS so that the distribution frequency of any statistical indicator can be obtained.

A.3.15.1.22 Evaluate statistical profiles of all individual recipients within each peer group, indicator by indicator, against the exception criteria.

A.3.15.1.23 Evaluate statistical profiles of all individual providers within each peer group, indicator by indicator, against the exception criteria.

A.3.15.1.24 Generate reports upon request that contain the maximum detail information possible on any recipient or provider.

A.3.15.1.25 Ensure that the system contains the data, functionality and reports as required for federal certification.

A.3.15.1.26 Implement controls and balancing on SUR load process.

A.3.15.2 SURS Inputs and Outputs

This table lists information about specific files that are used in the TCMIS SUR processes. The Contractor shall ensure continuity of these file processes, as they become available.

Interface Fraud and Abuse Subsystem	**Entity/ Vendor**	**Input/ Output**	**Freq**	**Destination/Info/Description**
State wage files	Dept. of Labor and Workforce Development	Input	Quarterly	Used to validate employment and income.
SSA files (comparison of aged and disabled groups)	SSA Death Match Index	Input	Monthly	Used to validate death for disenrollment.
Immigration records	Federal Government	Input	If required	Deferred
Wage files for federal employees and U.S. Postal Service employees.	Federal Government	Input	As available	Deferred
Motor Vehicle File	Tennessee Dept. of Safety	Input	As available	Driver's license, vehicle accidents with injury, vehicle registrations Deferred
Sanction file	HHS-OIG/ CMS	Input	As available	Sanction reports, FID, OSCAR, MED Deferred

Interface Fraud and Abuse Subsystem	Entity/ Vendor	Input/ Output	Freq	Destination/Info/Description
Veteran's Administration file	Veteran's Administration	Input	As available	Deferred
Property records	State Comptroller & Website	Input	As available	(property records) Deferred
iC Claims Extracts	iC database	Output	Quarterly	DSS
iC Code Table Extracts	iC database	Output	Quarterly	DSS
iC Managed Care Extracts	iC database	Output	Quarterly	DSS
iC Provider Extracts	iC database	Output	Quarterly	DSS
iC Recipient Extracts	iC database	Output	Quarterly	DSS

A.3.15.3 SURS Bureau Responsibilities:

A.3.15.3.1 Review all SURS reports submitted by the Contractor to determine the adequacy of content, format, frequency and media.

A.3.15.3.2 Communicate to the Contractor the selection options and definitions of parameters.

A.3.15.3.3 Provide the Contractor with file interface information with federal and State agencies and their contractors as necessary.

A.3.16 Managed Care

Managed Care Contractors (MCCs) provide a comprehensive range of health care services to TennCare enrollees through a network of health care providers.

The Bureau contracts with several Managed Care Organizations (MCOs), and the contract arrangements with each may vary. Most of the MCOs provide all physical health care services and behavioral health but not long term care, dental, and pharmacy services. As part of the LTC CHOICES Enhancement, long-term care services will be integrated with MCC services.

A Dental Benefits Manager (DBM) provides dental services for children.

A Pharmacy Benefits Manager (PBM) provides pharmacy benefits for TennCare enrollees.

The managed care functions are integrated in the interChange TCMIS in various subsystems:

Eligibility

Enrollment

Claims/Encounters

Electronic Data Interchange (EDI)

Early and Periodic, Screening, Diagnostic, and Testing (EPSDT)

Financial

Fraud and Abuse

Management and Administrative Reporting (MAR)

Provider Data Maintenance

Third Party Liability (TPL)

A.3.16.1 Contract Management of Managed Care Contractors

The Office of Contract Compliance and Performance (OCCP) is responsible for oversight of MCC compliance with directives arising from an appeal and requests for corrective action plans from the business areas. The Contract Management function shall include those activities associated with managing and monitoring the Bureau MCC contracts, including:

MCC Contract Management

MCC Monitoring

Interagency Agreements (Clarification: Interagency Agreements are handled by Fiscal Services rather than OCCP)

Other contracts (Clarification: Other contracts are handled by Fiscal Services rather than OCCP)

The business objectives of the OCCP are:

Receive and take action on written directives issued by TSU and LSU resulting from appeals and follow-up to ensure all mandated actions are completed by the MCCs within the designated timeframe.

Follow-up on all corrective action plans issued by the Bureau business units to ensure the MCCs respond within the designated time frame.

Receive, review, and forward all marketing materials from the MCO/BHO to the Marketing Review Committee for approval prior to the MCO/BHO producing these materials for TennCare enrollees.

Assess penalties (e.g., liquidated damages and/or withhold of capitation payment) to the MCCs, when appropriate.

Business processes to assess contract compliance activities include:

Perform audits on the MCOs and BHOs to monitor their financial net worth (solvency) and reserves.

Conduct onsite claims processing audit for each MCO/BHO annually to assess accuracy of claims processing.

Review weekly claims processing reports and activity reports from the MCO/BHO.

Analyze the MCO/BHO quarterly and annual financial statements for solvency.

Currently there are multiple systems that are handled by Fiscal Services to manage TennCare contracts. The goal is to make all the systems balance and reconcile for all areas. The systems are as follows:

a) Contract funding system – tracks where the contract is and the dollars committed within a certain timeframe. This system produces reports for TennCare Fiscal/Budget Unit by State fiscal year or federal fiscal year.

b) Tracking system – this system tracks the contract status during the process through completion of the contract.

c) TCMIS – processes all payments to the fee-for-service providers for claims payments, fees for the PBM and DBM, MCO and BHO capitation payments and administrative fees paid to the ASO.

d) STARS – The expenditures are tracked through a cost center code assigned by the TennCare Fiscal/Budget Unit. The assigned cost center codes are then cross-walked to selected cost centers, which produce the draw down from CMS for matching funds. STARS controls the dollars paid, timing of the payments and draw down from CMS.

The Contract Management functions in interChange support the management of the following contracts:

Managed Care Organizations (MCO)

Behavioral Health Organizations (BHO)

Pharmacy Benefits Manager (PBM)

Dental Benefits Manager (DBM)

Interagency Contracts - Example: contracts with State agencies such as DCS

Other Vendor Contracts - including the contracts the Bureau enters with other organizations (e.g., EDS, FOX, MedStat).

Contract Management functions incorporate components from several areas of the system to aid in monitoring and tracking the various contracts.

Provider, recipient, and encounter data within interChange are used to support many of the various auditing and reporting requirements.

The Siebel and FileNet tools are utilized for most of the workflow management requirements.

The Oracle Financial tools in the Accounting subsystem are used for most of the financial balancing and reporting requirements.

A.3.16.2 Managed Care/Enrollment

Managed Care Contractors (MCCs) provide medical services to Medicaid program recipients and recipients who have been determined to be “Medically Eligible” or uninsurable. Most recipients have an MCO for their primary care and medical/surgical services, a BHO to provide mental health and substance abuse treatment services, and a PBM who provides pharmacy services. Children under age twenty-one (21) are eligible to receive dental services, which are provided by a DBM. Note: Some enrollees are enrolled with MCOs whose contract arrangement requires

them to provide both medical *and* mental healthcare, and these enrollees will not have a separate BHO. Enrolled recipients receive:

Health care services covered under the Managed Care Organization (MCO);

Mental health services covered under the behavioral health organization (BHO), unless the enrollee is enrolled with one (1) of the newly enrolled MCOs; and

Additional benefits covered by "carve outs" for pharmacy and for dental benefits.

The Enrollment functional area has responsibility for the following;

Recipient Enrollment and Eligibility

Auto-assignment of Recipients

Capitation Payment Information

Enrollment Rosters

Mass Disenrollment and Mass Transfer of Recipients

Ballot Processing

BHO Assessment Processing

All persons eligible for Medicaid under DHS eligibility rules are referred to as TennCare Medicaid. Those who do not qualify for Medicaid may qualify for TennCare Standard, if they meet the State's requirements for Medical Eligibility (ME).

Based on TennCare's eligibility rules, a recipient may only qualify for mental health services. They will have behavioral health enrollment with a BHO only (no MCO). These are referred to as "State only" recipients or "judicial" recipients.

All other persons eligible for TennCare are enrolled in a Managed Care Organization (MCO) and a Behavioral Health Organization (BHO), except for Qualified Medicare Beneficiaries (QMBs) and Specified Low Income Medicare Beneficiaries, (SLMB).

A.3.16.3 MCO Assignment Distribution Process

TennCare enrollees are assigned to an MCO that provides health care services that provides mental health services. The "auto assignment" is the batch process that assigns beneficiaries to an appropriate MCO based on the following:

Recipient demographic information;

Recipient eligibility information and type of TennCare program; and

Recipient enrollment information.

In the current defined strategy of the Bureau, there are four (4) different levels of assignments in the auto assignment process:

1) Previously Assigned MCO: based on the existing enrollee MCO assignment information in the system;

2) Case Wrap: based on the existing enrollee's related case assignment information in the system;

3) Pre-determined: infants (less than one (1) year old) who were not manually assigned are allowed to connect to their mother's MCO; and

4) Random Assignment: if none of the above, then the system will determine the best applicable MCO assignment based on specific Bureau defined criteria.

Specific details may be found under the Enrollment Functional area in the iC PWB.

A.3.16.4 Contractor Requirements for Managed Care:

A.3.16.4.1 Ensure that the system contains managed care data required by CMS for certification, including description and documentation of interfaces, information collection processes, and transfer and control procedures.

A.3.16.4.2 Maintain and operate the managed care functionality that is integrated into the TCMIS.

A.3.16.4.3 Maintain and operate the managed care functionality to accommodate both capitated/prepaid and primary care case management reimbursement methods, as required for certification.

A.3.16.4.4 Maintain and operate the automated enrollment and disenrollment of beneficiaries.

A.3.16.4.5 Maintain and operate the generation of enrollment/disenrollment information that is utilized to perform reconciliation of State and managed care plan memberships.

A.3.16.4.6 Maintain and operate the functionality to generate enrollment/disenrollment/change information to beneficiaries.

A.3.16.4.7 Maintain functionality to reconcile capitation payment rates to plans against Bureau enrollment files.

A.3.16.4.8 Maintain beneficiary files that contain enrollment and plan information as required for certification.

A.3.16.4.9 Maintain and process payment of claims for services that are not included in managed care plans (e.g., wrap around services).

A.3.16.4.10 Maintain functionality to process encounter data that is received from managed care plans.

A.3.16.4.11 Maintain functionality to edit encounter data and store in beneficiary and claims history files as required for certification.

A.3.16.4.12 Maintain functionality to systematically enroll/disenroll beneficiaries into Primary Care Case Management (PCCM) plans.

A.3.16.4.13 Maintain functionality to generate case management fees which are paid as a

part of the claims payment function within the TCMIS.

A.3.16.4.14 Maintain functionality to automatically reconcile payments to case management providers against enrollment files/list.

A.3.16.4.15 Maintain functionality to process PCCM beneficiary files that are coded to allow for payments of non PCCM provider services.

A.3.16.4.16 Ensure that enrollment/disenrollment/change data is processed and documented as required for certification.

A.3.16.4.17 Ensure that Plan record keeping and reimbursement data is processed and documented as required for certification.

A.3.16.4.18 Ensure that data collection and reporting functions are documented and perform according to CMS certification standards.

A.3.17 Management and Administrative Reporting - MAR

The Management and Administrative Reporting (MAR) system is a comprehensive management tool utilized by the Bureau to provide information on program costs, provider participation and utilization trends. The MAR reports provide management the capability to analyze these historical trends and predict the impact of policy changes on programs. MAR reports are designed to assist management and administrative personnel with budget projections for TennCare by providing statistical information on key TennCare program functions necessary to support the decision-making process.

MAR reports are designed to supply detailed data on TennCare business processes and summary information for the Bureau's business areas, which are:

Administrative, including program status and performance, expenditure rates, financial planning, fiscal control, and federal reporting;

Operations, including claim throughput performance, sources of provider payment delay, claim filing problems, and claim error rate experience;

Provider activity, including participation rates, provider claim filing statistics, and cost settlement details;

Enrollee and Member activity, including eligibility and participation totals and trends by category of service and aid types; and

Third party liability activity, including claim activity with potential post payment collection and summarization of recoveries.

A.3.17.1 <u>MAR Contractor Requirements:</u>

A.3.17.1.1 Support functionality needed to compile information from various interChange TCMIS files/database tables for MAR federal reporting requirements.

A.3.17.1.2 Maintain functionality to generate, submit, and correct, if necessary, Medicaid Statistical Information System (MSIS) files and/or cartridges for CMS, according

to CMS time frames and as defined by the Bureau.

A.3.17.1.3 Update and maintain the Management Reporting User Manual for Contractor and Bureau personnel use.

A.3.17.1.4 Update system and operations documentation when system changes are made.

A.3.17.1.5 Generate MAR reports to be used to prepare budget allocations for various categories of service for the fiscal year.

A.3.17.1.6 Generate MAR reports to present claims processing and payment information to determine if providers are being reimbursed without unnecessary delay.

A.3.17.1.7 Produce reports to analyze claims processing by categories of service to determine where the greatest areas of delay exist.

A.3.17.1.8 Produce management reports used to review errors in claims processing to determine those errors most frequently committed by providers and claims processing personnel in order to improve training and forms.

A.3.17.1.9 Generate reports that shall be used to develop third party payment profiles to determine where program cost reductions might be achieved.

A.3.17.1.10 Generate reports to assist auditors in reviewing provider cost and establishing a basis for cost settlement.

A.3.17.1.11 Generate reports to establish per diem rates and monitoring accumulated liability for deficit payments.

A.3.17.1.12 Generate reports that shall be used to analyze the timing of provider claim filing to ensure good fiscal controls and statistical data.

A.3.17.1.13 Produce reports to monitor individual provider payments.

A.3.17.1.14 Generate and prepare reports on individual drug usage.

A.3.17.1.15 Maintain functionality to generate geographic analysis of expenditures and recipient participation.

A.3.17.1.16 Generate MAR reports to project the cost of program services for future periods.

A.3.17.1.17 Generate MAR reports to compare current cost with previous period cost to establish a frame of reference for analyzing current expenditures.

A.3.17.1.18 Generate MAR reports to compare actual expenditures with budget to determine current and projected financial position.

A.3.17.1.19 Generate MAR reports used to analyze the various areas of expenditures to determine the areas of greatest cost.

A.3.17.1.20 Generate MAR reports to facilitate the review of the utilization of services by various recipient categories to determine the extent of participation and relative cost.

A.3.17.1.21 Generate MAR reports used to analyze the break-even point between Medicare and Medicaid payments.

A.3.17.1.22 Generate MAR reports to analyze progress in accreting eligible Medicare Buy-In recipients.

A.3.17.1.23 Provide information to be reviewed concerning provider participation with respect to number of recipients and analyzing the capacity of providers to handle projected service demands.

A.3.17.1.24 Ensure that reporting provides utilization/cost reporting for certification and is used to monitor the usage and costs of services provided to beneficiaries on a periodic basis.

A.3.17.1.25 Ensure that reporting provides detailed health care utilization/costs data for certification, to establish capitation rates, determine cost effectiveness of capitated plans and compare prepaid costs with those incurred by fee for service populations.

A.3.17.1.26 Ensure that reporting provides data to support the development of service delivery standards/guidelines for certification that may be used to monitor health plan performance in the areas of access and services provided.

A.3.17.2 MAR Inputs and Outputs

The following table lists information about specific files that are used in the TCMIS MAR processing. The Contractor shall be expected to maintain these file processes.

Interface MAR	**Entity/ Vendor**	**Input/ Output**	**Freq**	**Destination/Info/Description**
IC Database	Internal	Input	N/A	N/A
MSIS Inpatient Claims File (CLAIMIP)	interChange	Output	Quarterly	CMS
MSIS Long Term Care Claims File (CLAIMLT)	interChange	Output	Quarterly	CMS
MSIS Pharmacy Claims File (CLAIMRX)	interChange	Output	Quarterly	CMS

Interface MAR	Entity/ Vendor	Input/ Output	Freq	Destination/Info/Description
MSIS All Other Claims File (CLAIMOT)	interChange	Output	Quarterly	CMS
MSIS Eligible File (ELIGIBLE)	interChange	Output	Quarterly	CMS

A.3.17.3 MAR Bureau Responsibilities:

The Bureau shall be responsible for ensuring that the Management and Administrative Reporting System provides the data that is required to generate the federally mandated reports. The reports are used by federal, State, and TennCare management to monitor and manage financial status, fiscal planning and control, operational planning, provider participation, recipient participation, drugs, and claims processing.

The information is retrieved from interChange and other TCMIS files/database tables to conduct the analysis and statistical summarizations.

A.3.17.3.1 Determine the format, content, frequency, media, number of copies, and distribution of reports produced by the contractor.

A.3.17.3.2 Approve, in writing, the content, format, and documentation of all management reports.

A.3.17.3.3 Initiate or approve report changes, additions, deletions, and other maintenance to management reporting functions.

A.3.17.3.4 Initiate and interpret policy and make administrative decisions resulting from the review of management reports. Monitor Contractor duties concerning the production of management reports and their transmission and distribution.

A.3.17.3.5 Define State and federal budget categories of service, categories of eligibility, provider type and specialty codes, county codes, collection account codes, and any other codes necessary for producing summary data.

A.3.17.3.6 Monitor production of all management reports and review reports produced to ensure compliance with Contract requirements.

A.3.17.3.7 Review balanced reports and Contractor documentation demonstrating that reports have been balanced to ensure internal and external report integrity.

A.3.17.3.8 Provide the Contractor with information necessary to complete the benefits portion of the CMS-64 Quarterly Statement of Expenditures, including, but not limited to, Title XIX expenditures and information necessary to adjust paid claims to report expenditures in compliance with State or federal requirements.

A.3.17.3.9 Provide the Contractor with additional information that is required for the production of specified management reports.

A.3.17.3.10 Receive all requests for data on the medical assistance programs that require the use of the management reports. Refer complex requests to the Contractor.

A.3.17.3.11 Select those providers for which cost settlement reports are to be prepared.

A.3.17.3.12 Direct the Contractor to make changes in the Management Reporting component of the TCMIS as a result of changes in policy and/or budgetary appropriation.

A.3.17.3.13 Review written recommendations for improvement by the Contractor.

A.3.18 Provider

A.3.18.1 Provider Networks

Managed Care Contractors (MCCs) are required to maintain adequate provider networks and shall meet the State's geographical access standards, as well as adhere to the following provider network guidelines:

A.3.18.1.1 Networks shall include specified safety net providers for specified safety net services;

A.3.18.1.2 Networks shall include at least one (1) Center of Excellence for individuals with HIV/AIDS in each of the Grand Regions in which the MCO participates;

A.3.18.1.3 Networks shall include Centers of Excellence identified through the State's EPSDT program for treatment of children in State custody;

A.3.18.1.4 Networks shall include adequate numbers of physician specialists to meet the needs of the enrolled population;

A.3.18.1.5 MCOs are encouraged to contract with Federally Qualified Health Centers (FQHC). If an MCO chooses not to contract with FQHCs, it shall demonstrate that its network is adequate and shall ensure that it has the needed capacity and range of services for vulnerable populations;

A.3.18.1.6 MCOs shall contract with local health departments for EPSDT screenings, until they can demonstrate that they are capable of meeting the EPSDT screening goals.

A.3.18.1.7 MCOs shall also maintain appropriate case management systems to ensure that enrollees receive all necessary services on a timely basis.

A.3.18.1.8 The Bureau's Provider Network Unit monitors the adequacy of provider networks and access standards. Using a Geo-Access product, geographic reports are produced to determine access ratios. If adequacy standards are not met, the Provider Network Unit sends a letter to the MCC detailing the issues and

requesting a Corrective Action Plan (CAP). The Provider Network Unit measures the timeliness of receipt of the Corrective Action Plans and whether or not they meet the criteria for compliance. For contract non-compliance, withholds may be implemented.

A.3.18.2 Provider Enrollment, Credentialing and Network Management

The Bureau is responsible for Provider Enrollment, Provider Credentialing, Provider Relation functions and Network Management.

A.3.18.2.1 Provider Enrollment

The Bureau Provider Enrollment Unit is responsible for establishing the requirements and enrolling Medicare providers billing crossover claims, TennCare only providers, and out-of-state providers of all types into the TennCare program.

The Provider functional area maintains records for all providers, and receives provider file changes from MCCs, TennCare providers, and CMS.

Medicare sends the Bureau a notification letter for each new provider enrolled in Medicare. The letter includes basic provider information such as provider name, UPIN, effective date, group number (if applicable), practice location, and “pay to" information. The Provider Enrollment Unit assigns a unique number to each Medicare provider before a crossover claim can be billed to the Bureau. TennCare-only providers are also assigned a unique TennCare provider number. These providers include, but are not limited to: pediatricians, obstetricians, pharmacies, nurse midwives, dentists, and out-of-state providers. CMS assigns provider numbers for SNF and Hospice providers.

MCCs provide an electronic file of their contracted providers. Each MCO assigns a unique provider number to each of their contracted providers.

Providers are to be added to the file by electronic and manual file update by the Contractor.

The DCS signs a new contract with a provider of services and a rate is established annually. DCS sends the new provider information to the Bureau to be manually entered into the TCMIS. The Contractor shall establish a billing (group) provider number in the system. The individual providers who are contracted to DCS are placed under the DCS group number with "pay to" information to the Children's Health Plan.

A.3.18.2.2 Provider Relations/Inquiry

The Provider Relations/Inquiry unit responds to telephone and written inquiries from providers and to complaints from providers, enrollees, and other interested parties.

A.3.18.2.3 Provider Credentialing

Provider credentialing is a function of the Bureau Medical Director who verifies required licenses and certifications, including specialty credentials. If Medicare has issued a Medicare provider number then the Bureau automatically enrolls the provider. Each contracted MCC plan is currently responsible for credentialing their providers. The Bureau does not track and report license and contract renewal status. A provider who contracts with multiple MCC plans is required to be credentialed by each plan.

A.3.18.2.4 Network Management

The Network Management Unit monitors the adequacy of provider networks and access standards. Using a Geo-Access product, geographic reports are produced to determine access ratios. If adequacy standards are met, the process ends. If adequacy standards are not met, the Bureau sends a letter to the MCC detailing the issues and a corrective action plan is required for correcting network deficiencies. The Bureau is required to provide a quarterly report to CMS. In addition, the Tennessee External Quality Review Organization (EQRO) conducts independent reviews of the MCCs to assess network adequacy.

A.3.18.3 Provider AVRS

The Automated Voice Response System (AVRS) is part of an overall TennCare Computerized Telephony System (CTS) solution. All calls pass through the AVAYA phone system, and are routed to the AVRS.

The AVRS platform is an Inter-voice rack based TRM-520 configuration with a Text-to-Speech (TTS) Server. The configuration for the Bureau of TennCare's system consists of two (2) TRM-520s, each having a dual Pentium III 1.26 GHZ processor and two (2) GB RAM licensed for forty-eight (48) ports of telephony, for a total of ninety-six (96) ports. The ports are connected via two (2) line-side T1s from the AVAYA phone system to each of the AVRS Servers. The forty-eight (48) ports on each system are configured as forty-four (44) inbound ports, three (3) outbound fax ports and one (1) test port. The configuration provides an AVRS capable of handling eighty-eight (88) simultaneous inbound calls, six (6) simultaneous outbound fax calls, and two (2) simultaneous test calls.

The two (2) systems are designed to run twenty-four (24) hours per day, seven (7) days per week, with scheduled maintenance windows. Both Servers run the same applications and are able to handle the same types of calls, allowing one (1) system to be taken down for maintenance during low volume periods, without affecting performance or losing calls.

The AVRS prompts the caller for information and sends the information in an Extensible Markup Language (XML) formatted Hypertext Transfer Protocol (HTTP) request to a Transmission Control Protocol/Internet Protocol (TCP/IP) socket on the TCMIS running a Simple Object Access Protocol (SOAP) Server. The SOAP Server routes the request to the appropriate inquiry service, which queries the TCMIS database and returns the requested information in an XML formatted response to the SOAP Server. The SOAP Server routes the response back to the AVRS request process. The AVRS then parses the response and speaks the information back to the caller. The request/response time is designed to be sub-second.

The TTS Server is shared by the two (2) TRM-520 systems and converts text returned by the TCMIS, such as the eligibility benefit plan and enrollee name, to speech to be spoken to the caller.

A.3.18.4 Provider AVRS Application

The Bureau supplies providers and Managed Care Contractors (MCCs) with the necessary information for appropriate care of TennCare members. In some cases, information may be automated. Providing access to information through an AVRS system provides an alternative to callers for immediate access to information, without requiring contact with a customer service representative. Callers are assigned an ID and Personal Identification Number (PIN) and are required to authenticate themselves before accessing information. Callers are also able to request eligibility information be received by facsimile.

The Provider AVRS application supports automated information for the following functions:

Recipient eligibility status (Includes MCO and BHO enrollment)

Third-party liability (TPL)

Claim status

Last check write and date

A.3.18.5 Provider Contractor Requirements:

A.3.18.5.1 Maintain the TCMIS functionality to provide information needed to monitor the enrollment of MCC provider networks to ensure access and network adequacy. The information shall also allow users to ensure that enrolled TennCare providers are qualified to render specific services by documenting State licensure and certification, specialty board certification, and federal participation requirements.

A.3.18.5.2 Support the Provider component to record and identify enrollment of providers contracted to MCCs.

A.3.18.5.3 Maintain current capabilities for provider enrollment data creation, updating, maintenance and termination online in real time, by Bureau staff.

A.3.18.5.4 Maintain provider database, including demographic data, as specified by Bureau and federal requirements, practice type, and plan participation.

A.3.18.5.5 Maintain the central provider database, which is accessible (24) twenty-four hours per day, seven (7) days per week from multiple access paths, and serves as a control file for provider information, practice type and plan participation.

A.3.18.5.6 Maintain the process to assign a unique identifying number for each provider enrolled in TennCare.

A.3.18.5.7 Maintain functionality to cross reference current and prior provider identification numbers and tax ID under a single TennCare provider identifier.

A.3.18.5.8 Maintain functionality to track multiple addresses and service locations for a provider and carry a start and stop date on each record when a provider leaves one (1) group and joins another.

A.3.18.5.9 Maintain functionality to track and report status on provider enrollment application processing, provider agreements, and certifications from application receipt to final disposition.

A.3.18.5.10 Maintain functionality to scan, store and retrieve and make available for online viewing all correspondence and documents associated with a provider's record.

A.3.18.5.11 Maintain a provider database that accepts group provider numbers and

associates an individual provider to his/her group using effective date processing.

A.3.18.5.12 Maintain the functionality to associate and track all relevant provider numbers (e.g., Medicare provider number, TennCare Identification Number, NPI, CLIA number, license number, SSN, Federal Employer Identification Number (FEIN), DEA, and NCPDP).

A.3.18.5.13 Maintain functionality to accept retroactive changes to the provider file.

A.3.18.5.14 Maintain the functionality to create an audit trail on who entered the change, when the change was made, and why the change was made.

A.3.18.5.15 Maintain provider history that will record changes to licenses, names, locations, or actions. All changes shall be marked with effective dates.

A.3.18.5.16 Maintain functionality to process the CMS provider sanction electronic file, comparing data to the master TennCare provider file. If a match is found, generate correspondence to alert associated MCCs that the provider is under CMS sanction.

A.3.18.5.17 Maintain the functionality to accept, track and report on written, telephone, and electronic provider inquires and make information available online real time.

A.3.18.5.18 Maintain edits for inputs of provider demographic and “pay to” information to ensure consistency and validity of information received through online data entry. Maintain the process to periodically reconcile this information.

A.3.18.5.19 Maintain process to associate all providers within a tax identification number to a group provider record on file and to an MCC contract.

A.3.18.5.20 Maintain process to update provider data and file records daily, weekly, and monthly in appropriate date sequence received from external sources.

A.3.18.5.21 Maintain edits of input data, both batch and online, for completeness and consistency, according to edit criteria established by the Bureau.

A.3.18.5.22 Support functionality to apply Provider File updates.

A.3.18.5.23 Generate provider mailings to selected providers based on Bureau defined criteria or by specified data fields, including welcome letters, outreach, bulletins, provider notices, and NPI letters, as directed by the Bureau.

A.3.18.5.24 Maintain functionality to track and report on select providers by zip code, provider type, provider specialty, program participation, taxonomy code and other Bureau defined criteria.

A.3.18.5.25 Maintain the functionality to generate standard correspondence, inquiry responses, and contracts to providers upon user request.

A.3.18.5.26 Maintain the ability to suppress printing of any automated notices for individual providers.

A.3.18.5.27 Maintain functionality to track and report provider enrollment statistics such as enrolled provider by financial fund code, chart of accounts, MCC, provider type, and provider specialty through online reports generated by interChange.

A.3.18.5.28 Generate reports (weekly, monthly, quarterly, and yearly summary reports) of activity related to inquiries regarding payment procedures for fee-for-service claims.

A.3.18.5.29 Maintain all provider demographic information to support claims/encounter processing and information management functions.

A.3.18.5.30 Maintain control over all data pertaining to provider enrollment, as directed by the Bureau.

A.3.18.5.31 Maintain the functionality to apply updates to the provider data set on a daily basis to reflect changes brought to the attention of the Contractor by the Bureau, providers, or its own staff. Maintain an audit trail of all changes.

A.3.18.5.32 Establish methods to edit and verify the accuracy of provider data entered into the TCMIS system.

A.3.18.5.33 Annually and as requested by the Bureau, purge inactive provider records to an archive file on a schedule using criteria specified by the Bureau.

A.3.18.5.34 Maintain an automated system for tracking and reporting written and telephone inquiries that ensures retrieval of the date and nature of the inquiry and the date and nature of the reply.

A.3.18.5.35 Facilitate the process to enable the Bureau to monitor all undeliverable mail to providers, and verify that future mail is sent to correct address.

A.3.18.5.36 Maintain the data and provide the functionality to generate provider 1099s.

A.3.18.5.37 Maintain functionality to generate and mail provider notices, bulletins or manuals, as directed by the Bureau.

A.3.18.5.38 Print and distribute provider notices, posters, bulletins, or manuals, as directed by the Bureau.

A.3.18.5.39 Provide other file maintenance and quality control of files, as directed by the Bureau.

A.3.18.5.40 Maintain an Internet version of bulletin boards or Internet provider manuals to facilitate communication among providers, DCS case workers, MCOs/BHOs and Bureau staff.

A.3.18.5.41 Provide data entry and verification of provider file maintenance (provider information and reimbursement schedules).

A.3.18.5.42 Prepare outreach materials for providers, with Bureau approval, in which TCMIS transition activities are identified, including, but not limited to, pertinent information regarding the new contract, addresses, phone numbers, billing manuals, and cutoff dates.

A.3.18.5.43 Make Bureau-authorized materials available to providers electronically. Conduct provider training sessions (promoting web-based or telephone dial-in media or, as the parties may agree, other training formats), as requested by the Bureau.

A.3.18.5.44 Operate the provider component of the TCMIS, including improvements/enhancements as they are implemented.

A.3.18.5.45 Maintain and update the affiliations between group practices and group members, in accordance with Bureau requirements.

A.3.18.5.46 Update the Provider Master File/Database on a daily basis to reflect changes brought to the attention of the Contractor by the Bureau, providers, or from within.

A.3.18.5.47 Provide online inquiry and real-time update access, based on appropriate security, to the Provider Master File/Database. Update access shall be limited to designated personnel, as specified by the Bureau.

A.3.18.5.48 Maintain an audit trail of all update transactions applied to the Provider Master File/Database.

A.3.18.5.49 Maintain all demographic and rate information to support claims processing and reporting functions.

A.3.18.5.50 Maintain a cross-reference of Medicaid-Medicare provider numbers to support crossover claims processing.

A.3.18.5.51 Maintain all financial fund codes and the Federal Employer Identification Number (FEIN) for which a provider is allowed to bill.

A.3.18.5.52 Generate all Bureau required provider reports.

A.3.18.5.53 Prepare and produce data for provider audits, quality assurance, and cost settlement reporting.

A.3.18.5.54 Maintain data on health plan affiliations for each provider.

A.3.18.5.55 Update system and operations documentation when system changes are made.

A.3.18.5.56 Sample remittance advice statements and provider claim reports to ensure correctness prior to making available to providers.

A.3.18.5.57 Ensure that all NPI requirements are implemented according to the timelines established by CMS.

A.3.18.5.58 Ensure that all associated provider numbers are linked to eliminate the problem of providers having multiple Provider IDs.

A.3.18.5.59 Provide capability to provide system-generated letters as to the approval or disapproval for provider participation or continued participation in TennCare. This shall apply to individual and group providers.

A.3.18.5.60 Provide edit capability to prevent duplicate provider enrollment during add or update transactions. Provide capability to recognize and generate a monthly alert for duplicate entries and suspected duplicate provider numbers.

A.3.18.5.61 Provide capability to automatically renew the provider license, as directed by the Bureau.

A.3.18.5.62 Maintain links for financial recoupment purposes for providers with the same Tax ID within the TCMIS.

A.3.18.5.63 Maintain functionality to ensure that transaction records are matched to the provider master record by means of a unique provider number.

A.3.18.5.64 Release error records from the provider error suspense file as errors from previous runs are corrected.

A.3.18.5.65 Print transaction and error lists to provide an audit trail of all transactions processed.

A.3.18.5.66 Maintain a pending applications file to ensure that action is taken on every application.

A.3.18.5.67 Print a provider control report for reconciliation with manual transaction control log.

A.3.18.5.68 Print approval notice form or rejection notice form.

A.3.18.5.69 Print provider applications pending report.

A.3.18.5.70 Ensure that all files are labeled and checked by the computer so that only the proper file can be used for each processing run.

A.3.18.5.71 Maintain control totals and processing dates, and make certain that all data processing records are accounted for on each processing run.

A.3.18.5.72 Maintain provider and associated data to support provider functionality as required for federal certification, and also produce reports as required.

A.3.18.5.73 Maintain Provider database to ensure that it contains the required certification

data elements.

A.3.18.5.74 Maintain functionality to ensure that all data items are edited according to certification requirements.

A.3.18.5.75 Maintain functionality to ensure that all updates to the provider master file contain valid transactions.

A.3.18.5.76 Maintain functionality to produce provider information and current status of provider's history.

A.3.18.5.77 Maintain functionality to retain all transactions in error on the provider error suspense file.

A.3.18.5.78 Print an aged provider error listing for follow-up on unresolved errors.

A.3.18.5.79 Utilize CTS for provider enrollment.

A.3.18.5.80 Scan and index the provider enrollment form and create a folder format to add updated information from the provider.

A.3.18.5.81 Scan all provider documentation and correspondence within a timeframe as defined by the Bureau, including the assignment of a unique identifier to be defined by the Bureau that allows for retrieval and tracking.

A.3.18.6 Modification of Functionalities Requirements:

The following requirements are functionalities that shall be developed and implemented by the Contractor after Bureau approval.

A.3.18.6.1 Maintain an automated mechanism of assigning unique provider numbers.

A.3.18.6.2 Maintain the use of the National Provider Identifier (NPI) to ensure compliance with HIPAA as required.

A.3.18.6.3 Maintain a Provider Master File/Database in which each provider has a unique identifying number (the provider number) and NPI, including all data elements required by the Bureau.

A.3.18.6.4 Perform quality assurance of data in the Provider Master File/Database and submit results to the Bureau.

A.3.18.7 Provider Inputs and Outputs

The following table lists information about specific files that are used in TCMIS Provider processing. The Contractor shall be expected to maintain these current Provider file processes.

Interface Provider Subsystem	Entity/ Vendor	Input/ Output	Freq	Destination/Info/Description
Sanction File	OIG	Input	Weekly	This is the List of Excluded Individuals and Entities file downloaded from the Office of the Inspector General's Website. This file is used to replace the interChange Sanction master file.
License File	External	Input	Monthly	These files are transmitted to the Contractor from an outside agency with the license information. The files may come from the State Licensure Board, the State Pharmacy Board, and the Centralized Verification Organization (CVO). The files update the interChange License master file on a monthly basis.
Multiple Letters and Reports	MCCs	Output	Weekly	These files are transmitted to the Contractor from each MCC. The data is used to update the MCC group affiliations in interChange.

A.3.18.8 Provider Bureau Responsibilities:

A.3.18.8.1 Communicate to the Contractor the provider eligibility requirements for all new providers enrolled through the Provider Enrollment Unit for possible impact to TCMIS program editing logic.

A.3.18.8.2 Review and approve all provider communications materials.

A.3.18.8.3 Process all requests for provider enrollment, including reviewing returned packets for completeness and obtaining missing information.

A.3.18.8.4 Track the status of provider enrollment applications.

A.3.18.8.5 Verify required licenses and certifications, including specialty credentials. Educate providers across the State through the web and other sources about the TennCare program and policies including provider bulletins and news letter.

A.3.19 Electronic Data Interchange (EDI)

The EDI function is actually an interface into the TCMIS for external entities. External transactions are received by the TCMIS through a common service which performs data translation, statistical reporting, and transaction routing to the appropriate TCMIS functional area.

The job in each functional area accepts the transactions, performs the necessary processing, and updates the TCMIS databases as required.

The Bureau complies with HIPAA electronic data interchange (EDI) standards by accepting and responding to the electronic file submissions for eligibility/enrollment, provider remittance advices, TPL information, claims and encounters from business partners, providers, and intermediaries. The TCMIS is required to support the Bureau's requirements for electronic banking, including electronic funds transfer and compliance with the Federal Cash Management Improvement Act. The TCMIS also supports the Bureau's requirements for electronic eligibility verification, including use of Point of Sale (POS) terminal devices, PC based dial-up, host-to-host, and audio response. The electronic file interfaces include a wide variety of data exchange and file send/receive functions when processing enrollment, claims, encounters, third party insurance verifications, providers, remittances, Medicare Buy-In, and CMS reporting. An inventory of interface files is depicted in Section A.3.2 of this Contract and additional information may be found in the interChange PWB.

The Electronic Data Interchange (EDI) function provides the overall support of collecting, processing, and tracking and reporting on standard X12, NCPDP and HL7 data formats. The EDI system is an interface with the TCMIS, sending to and receiving from external entities.

MCCs and providers submit transactions using standardized communication protocols and data structures. Using the EDI system, these external entities communicate to the iC TCMIS, which contains the communications hardware that directs traffic to the iC Web Server, where the translator resides.

External batch input files call a translator to convert the standardized structure to XML. The batch programs send the translated XML to application directories to wait for further processing by the application services. Batch programs read the data from XML files or flat files and generate outbound standard format files.

A.3.19.1 <u>EDI Contractor Requirements:</u>

A.3.19.1.1 Support electronic commerce services, including the real-time interactive interface to the State operated virtual private network (VPN), electronic claims and remittances, electronic interfaces, and electronic transaction processing for: capitation (820), remittance advice (835), enrollment (834 inbound & outbound), eligibility (270/271 & 271U), claims related transactions (837 P/I/D & NCPDP), encounter data (837 P/I/D & NCPDP), coordination of benefits with other payers and carriers, including Medicare crossover claims, and any other transaction that the Bureau defines as a standard. Ensure compliance with HIPAA electronic data interchange standards.

A.3.19.1.2 Provide information by the web or VPN connectivity to providers, contractors and business partners regarding eligibility status for the date queried to third-party payers (including Medicare); enrollment in managed care plans and service restrictions information; benefit exhaustion information, including services or service limitations requiring prior authorization; spend down information; information on last check write amount and date; and pended claims information.

A.3.19.1.3 Accept electronic file submission(s) of all eligibility, provider, TPL, claims, and encounters from business partners, providers, and intermediaries.

A.3.19.1.4 Perform logic and data integrity editing to screen the submitted electronic transaction for compliancy before acceptance. Accept error free transactions, and reject and/or report, according to Bureau policy, transactions which fail edits.

A.3.19.1.5 Notify the submitter (online) shortly after file transmissions if the file submitted is acceptable for further processing. If errors are found, notify the submitter of errors and the nature of the errors, and accept for further processing records without errors.

A.3.19.1.6 Send electronic receipt files to submitters by “997” or other Bureau-approved feedback documentation.

A.3.19.1.7 Provide, and update as appropriate, a back-up translator system or business continuity process to ensure that no system downtime (due to hardware or software problems) occurs. This capability shall be developed in accordance with the Change Management process. Any related hardware, software or maintenance shall be procured in accordance with Section C.3 Payment, Paragraph (f) Hardware, Software and Maintenance.

A.3.19.1.8 Maintain and support internet accessibility and transaction processing through the TennCare Portal to support inquiry, create, update, and verification functions by approved users.

A.3.19.1.9 Support the following electronic commerce functions:

a. Eligibility verifications supporting a complete response dataset to include demographics, plan enrollment, TPL, co-pay, coinsurance, and deductible information, premium payment information, primary care physician, benefit plan, and service limit utilization

b. Claim status inquiry

c. Check Payment inquiry

d. Preadmission Certification: submit, update, and verify status

e. Address updates from providers

f. Turn Around Document 837I interface (TAD like claims): update, verify, and submit

A.3.19.1.10 The Internet function shall record an audit trail of all transactions and provide responses online for all transactions.

A.3.19.1.11 Maintain access through the VPN, Internet and the Automated Voice Response System (AVRS) in the TCMIS.

A.3.19.1.12 Provide access to the TCMIS database twenty-four hours (24) per day, seven (7) days per week to facilitate access to specific data that will be controlled by user

security levels approved by the Bureau.

A.3.19.1.13 Provide necessary EDI training, assistance and help desk support to TennCare providers, business partners, enrollees, Bureau personnel, and other end-users on the various inquiry functions, such as AVRS, as needed.

A.3.19.1.14 Produce, maintain, update, and distribute electronic copies of the electronic commerce system manuals, reference documents, and other documentation to business partners, providers and Bureau staff, as directed by the Bureau.

A.3.19.1.15 Maintain a confirmation number for each electronic transaction, eligibility verification and file submission.

A.3.19.1.16 Provide support for electronic banking, including electronic funds transfer, that ensures compliance with State of Tennessee requirements, CMS and the Cash Management Improvement Act agreements with the US Secretary of the Treasury.

A.3.19.1.17 Maintain the electronic commerce interface for submission, inquiry, verification, create, and update purposes for twenty-four (24) hours per day, seven (7) days per week.

A.3.19.1.18 Ensure that the response time for non Audio Response Unit (ARU) provider submitted transactions is not greater than two (2) seconds for ninety percent (90%) of the transactions and no response time is greater than five (5) seconds.

A.3.19.1.19 Notify the Bureau immediately when the inquiry system is down.

A.3.19.1.20 Notify all business partners immediately when EDI functionality is down.

A.3.19.1.21 Operate the electronic transaction component of the TCMIS, including improvements/enhancements as they are implemented.

A.3.19.1.22 Maintain the Electronic Transaction System to allow electronic submission of claims from providers using the interactive features of the Web Portal or the batch features of the Electronic Transaction subsystem.

A.3.19.1.23 Electronic claims should support the acceptance of the current standard version of 837 Health Care Claim transactions from Professional, Dental and Institutional providers. Acknowledge the receipt of X12N transactions with the standard 997 Acknowledgement Transaction.

A.3.19.1.24 Provide appropriate staff to handle both technical and informational responsibilities concerning electronic transaction functions.

A.3.19.1.25 Perform online, real-time logic and consistent editing of claims transmitted by the providers.

A.3.19.1.26 Ensure that all online edits conform to TCMIS edit structures and outcome

dispositions.

A.3.19.1.27 Maintain functionality to perform necessary logic and consistent editing for all submitted claim/encounter claim data.

A.3.19.1.28 Provide online notification to submitters, shortly after transmission, regarding any transmission or claim data errors, or acceptability for further processing.

A.3.19.1.29 Maintain control and tracking standards for claims submitted electronically.

A.3.19.1.30 Produce all defined and Bureau approved reports regarding electronic claims submissions.

A.3.19.1.31 Develop interactive processing of the ANSI X12N 276 Health Care Claim Status Request and interactive generation of the ANSI X12N 277 Health Care Claim Status Response when submitted, in accordance with the Change Management process.

A.3.19.1.32 Maintain functionality to assign transaction control numbers to electronic claims immediately upon acceptance.

A.3.19.1.33 Maintain functionality to receive and process claims (e.g., Medicare Crossover, encounters, fee-for-service) including original, replacement (adjustment), and voided claims within Bureau specified processing parameters.

A.3.19.1.34 Update system and operations documentation when system changes are made.

A.3.19.1.35 Provide onsite staff for management and support for the TCMIS translator.

A.3.19.1.36 Develop interactive processing of the ANSI X12N 278 Health Care Prior Approval Transaction when submitted, in accordance with the Change Management process.

A.3.19.1.37 Implement, maintain, and support new EDI standards, as directed by the Bureau.

A.3.19.1.38 Process 997s received by TennCare for TennCare submitted transactions. Develop automated process to immediately notify TennCare electronically of any 997 that is not fully accepted by the receiver, in accordance with the Change Management process.

A.3.19.2 <u>EDI Inputs and Outputs:</u>

The Input and Output files for EDI are standard X12, NCPDP, HL7 files and proprietary files. The Companion Guides may be found at: http://www.state.tn.us/tenncare/HIPAA/EDI.htm.

A.3.19.3 <u>EDI Bureau Responsibilities:</u>

A.3.19.3.1 Review and approve all operating policies and procedures.

A.3.19.3.2 Facilitate coordination with the Bureau portal vendor.

A.3.20 Facilities Manager General Operations

A.3.20.1 Facilities Manager Operational Requirements

A.3.20.1.1 General:

The Facilities Management operations shall be performed at the facility located at 310 Great Circle Road, Nashville, TN, where the State shall provide the following facility related items:

Utilities (electricity and water)

Local Area Network (LAN) Connectivity

Workstations for technical and support staff

Janitorial services

General facility security

Fire alarm and/or fire suppression system

Standard office furniture (e.g. desks, chairs, wall panels, shelves, file drawers).

The Contractor shall be responsible for providing the following:

Copiers, facsimile machines, personal office equipment

Provide any additional office equipment or landscaping, if desired.

Expendable supplies for Contractor staff

Liability insurance for Contractor staff and equipment.

Telephones shall be provided by the State, using the following rates:

Monthly service charge per set: $6.38

Long Distance for intralata per minute - $0.072

Long Distance for interlata per minute - $0.067

A.3.20.1.1.1 The Contractor shall operate and maintain the TCMIS and perform related Facilities Management functions in accordance with all federal, State, and Bureau requirements. This function is comprised of system operation, claims processing, mail room operations, customer/provider service, file maintenance, system functionality processing, system and operational support and user training.

A.3.20.1.1.2 The Contractor shall provide and maintain the capability to operate the production control and scheduling function at the Great Circle Road facility. Major requests to modify this schedule shall be submitted in writing to the Bureau for approval. Prior to implementation, the Bureau shall approve any and all major scheduling modifications. If required for completion of TCMIS processing, production control and scheduling functions may operate twenty-four (24) hours per day, seven (7) days per week until completed. In the event production control and scheduling

functions are not required for a specific period, the Contractor shall provide on-call support as agreed upon between the Bureau and the Contractor.

A.3.20.1.1.3 The Contractor shall ensure all hardware, software, protocols, processes, licenses, and communications are appropriately established.

A.3.20.1.1.4 The Contractor shall maintain the Edifecs SpecBuilder, XEngine and Transaction Manager software.

A.3.20.1.1.5 The Contractor shall correctly apply/upgrade to the most current version of Edifecs SpecBuilder, XEngine and Transaction Manager software, as approved in writing by the Bureau and procured through Section C.3 Pricing, Paragraph (f) Hardware, Software and Maintenance.

A.3.20.1.1.6 The Contractor shall maintain the Edifecs SpecBuilder software for guideline authoring, publishing and desktop testing, including utilizing the business edits, code sets and other requirements as defined by Bureau business processes.

A.3.20.1.1.7 The Contractor shall maintain the Edifecs XEngine software for routing, validation, splitting and acknowledgement generation, including, but not limited to, testing/validating for WEDI SNIP error types one through seven (1-7), which includes, but is not limited to: syntax, semantics, code sets, and trading partner specific business rules, as defined by the Bureau.

A.3.20.1.1.8 The Contractor shall maintain the Edifecs Transaction Manager software as of the Modified Start Date to ensure operational integrity and accountability in the transaction lifecycle by tracking both real-time and batch transactions and associated business or system events at each of the key processing points in the TCMIS and then by analyzing this information to provide a complete picture of the transaction lifecycle.

A.3.20.1.1.9 Assist the Bureau with problem identification and error resolution.

A.3.20.1.1.10 Apply configuration management tools to establish version control of the TCMIS.

A.3.20.1.1.11 Submit an operational problem/trouble report to the Bureau when operational problems (either systems-related or work flow-related) occur, describing the nature of the problem, the expected impact on ongoing functions, a corrective action plan, and the expected time to complete.

A.3.20.1.1.12 Prepare agenda, in conjunction with the Bureau, for periodic status meetings with Bureau staff. Status meetings shall include reporting on current operations, including scheduled maintenance, enhancement modification activities and any other items deemed necessary by the Bureau.

A.3.20.1.1.13 Maintain permanent retention (FileNet) of all reports.

A.3.20.1.1.14 Assist Bureau staff, agents, and affiliates in conducting audits through sample selection, data gathering, and documentation to support issue resolution, as directed by the Bureau.

A.3.20.1.1.15 Provide online access to the TCMIS and all of its components to Bureau staff, agents, and affiliates, as specified by the Bureau.

A.3.20.1.1.16 Monitor all file maintenance processes to ensure integrity of the files.

A.3.20.1.1.17 Monitor TCMIS report production to ensure that all reports, including, but not limited to, copies, are readable, accurate, and delivered on schedule.

A.3.20.1.1.18 Monitor the resolution of operational problems identified by the Contractor or Bureau staff.

A.3.20.1.1.19 Install Bureau software to monitor network availability and produce a weekly report that lists the average response times per terminal in the network and a monthly report that lists the number of minutes that the Bureau LAN experienced a disruption of system availability during the most recent monthly period.

A.3.20.1.1.20 Make written recommendations on any area in which the Contractor or Bureau thinks improvement can be made.

A.3.20.1.1.21 Ensure that the TCMIS data provided for the interfaced DSS (Fraud and Abuse database) system is accurate, current, and timely and in the appropriate format and media for acceptance by the associated DSS system. This includes data used in the suite of Business Objects tools that access the integrated relational database management system (RDBMS).

A.3.20.1.1.22 Maintain and coordinate with OIR the hardware functions in order to ensure peak efficiency including improvements/enhancements as required.

A.3.20.1.1.23 In the event that during the Contract term the hardware environment for Interchange needs to be upgraded, the Contractor shall be expected to migrate the system to the new hardware, and to test all applications during and after the migration.

A.3.20.1.1.24 Provide technical assistance, as needed, to users, including, but not limited to, development of specifications, research on problems, review of production output, and report formats.

A.3.20.1.1.25 Establish direct connections with Bureau approved business partners.

A.3.20.1.1.26 Re-index database tables as directed by the Bureau or as needed to ensure peak performance.

A.3.20.1.1.27 Provide online access to the TCMIS and interChange data to other Bureau contractors, and other State or federal agencies, as specified by the Bureau.

A.3.20.1.1.28 Assure all daily, weekly, monthly, quarterly, and annual cycles are run correctly and on time, as defined by the Bureau.

A.3.20.1.1.29 Perform and ensure accuracy of data extracts for Bureau business partners and deliver files within the timeframe as required by the Bureau.

A.3.20.1.1.30 Perform work as instructed by the Bureau. This may include extracting data from archived files.

A.3.20.1.1.31 Perform research immediately upon recognizing potential system problems in order to minimize system or payment impact and improve processing.

A.3.20.1.1.32 Proactively maintain and upgrade all hardware and software to support Contract uptime and response time.

A.3.20.1.1.33 Assure that all licensed products for the systems, including, but not limited to, the OS, databases, and communications are upgraded to the current, stable version. These products shall not be allowed to lapse into an unsupported version.

A.3.20.1.1.34 Enhance the software and component parts of the TCMIS (such as the TCMIS files and Web applications) as directed by the Bureau. Software enhancements may result when the Bureau or the Contractor determines that an additional requirement needs to be met which results in a change to existing file structures, data sets, or current processing logic.

A.3.20.1.1.35 Ensure that communication switches and network components outside the central computer room shall receive the level of physical protection necessary to prevent unauthorized access in facilities under the control of the Contractor.

A.3.20.1.1.36 All updates shall be reported to the Bureau and maintained on the online inquiry screens.

A.3.20.1.1.37 Ensure that prioritized requests from the Bureau are followed for scheduling work and resources.

A.3.20.1.1.38 Implement changes to the Job Control Language (JCL) or system parameters.

A.3.20.1.1.39 Perform changes to tables for edit/audit criteria; rate changes, individual or mass adjustments, including purging of files, facilitate research, and recycling.

A.3.20.1.1.40 Facilitate processing improvements such as tape to File Transfer Protocol (FTP) file conversions, activities, and changes necessary to implement corrective action plans.

A.3.20.1.1.41 Perform incident reporting (e.g., when a cycle contains errors, the system goes down, loading incorrect data).

A.3.20.1.2 <u>Mailroom:</u>

A.3.20.1.2.1 Distribute bulletins, notices, identification cards (for QMB-only eligible populations), and remittance advices and other documents to providers,

enrollees, MCCs and other entities, in accordance with a schedule defined by the Bureau.

A.3.20.1.2.2 Maintain an inventory of all Bureau forms and distribute to providers, MCCs and other entities upon request.

A.3.20.1.2.3 Open, sort, and distribute all Bureau mail beginning on July 1, 2009, and as subsequently received during the term of this Contract. The Contractor shall be responsible for picking up, processing, and the distribution of mail collected from all P.O. boxes, which are used for enrollee correspondence, claims, and adjustments, and Bureau of TennCare mail.

A.3.20.1.2.4 Provide local courier service at a frequency as required by the Bureau.

A.3.20.1.2.5 Produce and distribute all enrollee notices and letters, as directed by the Bureau.

A.3.20.1.2.6 Prepare and control incoming and outgoing TennCare mail, as directed by the Bureau, to ensure claims and other correspondence are picked up and delivered to any site designated by the Bureau in the most effective and efficient means available.

A.3.20.1.3 Local Data Center Operations:

A.3.20.1.3.1 Maintain Bureau LAN connectivity and provide technical support throughout the State to internal and external users of the TCMIS infrastructure.

A.3.20.1.3.2 Provide system security to safeguard access to data and ensure integrity, completeness, and accuracy of data; provide logons and levels of security for system users, and in accordance with HIPAA Security and Confidentiality requirements, State law, and Bureau policies and procedures and/or rules.

A.3.20.1.3.3 Operate and maintain a quality control program for system operations.

A.3.20.1.3.4 Maintain a Disaster Recovery Plan and Business Continuity and Contingency Plan for the TCMIS in cooperation with OIR and the Bureau and perform disaster recovery testing upon request in cooperation with OIR and the Bureau.

A.3.20.1.3.5 Schedule and run TCMIS jobs in accordance with the Bureau's approved production schedule. All outputs shall be delivered as identified in this Contract unless otherwise agreed upon between the Bureau and the Contractor in agreed media, format and number of copies.

A.3.20.1.3.6 Provide Bureau staff (or their designees) access to job execution information, or printed output that displays job execution information, (e.g., overrides, input parameters, dates) upon request.

A.3.20.1.4 File Maintenance:

A.3.20.1.4.1 Track and control all updates received electronically or on hardcopy, balanced, entered, and processed. Account for total transactions

received and account for any discrepancies along with taking the appropriate corrective action.

A.3.20.1.5 Reporting:

A.3.20.1.5.1 Provide management reporting to the Bureau for all aspects of the TCMIS. Assist the Bureau in definition and design of reports.

A.3.20.1.5.2 Update and maintain all data elements as required by the federal MMIS General Systems Design and such additional elements as may be necessary for the Bureau to meet all federal data set requirements for federal reporting.

A.3.20.1.5.3 Ensure all reporting is run on time, is correct, and is delivered according to the requirements of this Contract.

A.3.20.1.5.4 Perform data extracts for Bureau affiliates and deliver files timely.

A.3.20.1.5.5 Produce ad hoc reports as requested by the Bureau.

A.3.20.1.5.6 Produce and assist Bureau in definition and design of general system performance reports.

A.3.20.1.5.7 Operate the production report component (FileNet) of the TCMIS, including improvements/enhancements as they are implemented.

A.3.20.1.5.8 Maintain necessary data and provide all required reports relative to TennCare enrollees, providers and claim activity.

A.3.20.1.5.9 Support the production of all reports required by the Bureau on the media specified by the Bureau.

A.3.20.1.5.10 Produce a Report of Reports and ensure that all reports are being delivered to Bureau-specified delivery locations according to the distribution checklist.

A.3.20.1.5.11 Provide all current and future federally required reporting and all Bureau required reporting as directed by the Bureau. Included shall be accurate reports that support the management of the Bureau, as defined by the Bureau.

A.3.20.1.5.12 Provide capability to ensure all reporting cross-checks and balances to other agencies and vendor reporting are using the same data.

A.3.20.1.5.13 Develop and provide control totals and balancing information for all reports. Included shall be the capability for compiling subtotals, totals, averages, variances, and percents of items and dollars on all reports, as appropriate.

A.3.20.1.5.14 Provide capability to query on any one (1) element in the database as well as multi-data elements in the database to generate standard queries of summary and detail statistics by variables as defined by the Bureau.

A.3.20.1.5.15 Ensure the Quality Control Plan is followed and reported, ensuring accurate testing and reporting of maintenance and

modifications. Provide system checkpoints to ensure changes made to programs are accurately reflected in the report. Show the system can perform all integrated functions and can process all claim types from input through reporting. Specific claims shall be tracked by control number through the system. Ensure that all reports are produced, as directed by the Bureau, with one hundred percent (100%) accuracy and consistency.

A.3.20.1.5.16 Assure all reporting is run on time, is correct, and is delivered according to the requirements of this Contract.

A.3.20.1.5.17 Submit reports of system errors and failures within one (1) business day of the occurrence.

A.3.20.1.5.18 Report weekly to Bureau managers and directors, all systems changes that have been implemented. (Electronic reporting is preferred)

A.3.20.1.5.19 Ensure that all reports are produced, as directed by the Bureau, with one hundred percent (100%) accuracy and consistency. Included shall be balancing, uniformity, comparability of data to ensure internal and external validity, and subtotal-to-totals verification of the final summation. Inaccurate reports shall not be considered delivered until all errors are corrected.

A.3.20.1.6 <u>System Support:</u>

A.3.20.1.6.1 Perform overall operation and maintenance of the TCMIS including running all jobs in production as required.

A.3.20.1.6.2 Provide and maintain an administrative structure, including personnel, of sufficient background, training, size, scope, and authority to perform its contractual responsibilities to the satisfaction of the Bureau.

A.3.20.1.6.3 Perform impact analysis for new federal and State policies and procedures with alternatives and recommendations for system modifications and enhancements.

A.3.20.1.6.4 Perform all Takeover TCMIS operations activities and systems maintenance/modifications on-site at the Bureau's Nashville facility during the operational period.

A.3.20.1.6.5 Identify and inform the Bureau of any procedure or technology which may reduce the cost and/or increase the effectiveness of administering the TennCare program, including claims and encounter processing, capitation payments, eligibility determination and application processing, quality improvement, file maintenance, system operations, enrollee notification, and premium processing.

A.3.20.1.6.6 Provide and maintain adequate liaison and communication with the Bureau in connection with the Contractor's specified contractual responsibilities.

A.3.20.1.6.7 Provide and maintain books, records, reports, claims, files, documents, and other evidence pertaining to this Contract to the extent and in such detail as shall properly reflect conformance with this Contract and meet

federal and Bureau record retention requirements. Make these available for inspection by the Bureau or its designee.

A.3.20.1.6.8 Maintain TCMIS documentation (User Manual, Quick Reference Guide, Procedure and Operations Manuals) throughout the term of this Contract.

A.3.20.1.6.9 Provide the Bureau with the names of individuals who are authorized to act on behalf of the Contractor, together with a description of their responsibilities and authorities.

A.3.20.1.6.10 Provide ongoing training, including training plans and materials, for Bureau employees or designees.

A.3.20.1.6.11 Provide production control and scheduling function twenty-four (24) hours per day, seven (7) days per week.

A.3.20.1.6.12 The Contractor shall support the Non-Production TCMIS environments for Development, Training and Test/UAT Servers located outside of the OIR data center. This includes all the Unix and Wintel servers located at 310 Great Circle Road.

A.3.20.1.6.13 The Contractor shall provide two (2) full time equivalents (FTEs) to support the Production Windows Servers located outside of the OIR data center. This includes the Optical Character Recognition claim capture Servers located at 310 Great Circle Road, and the NICE Server at the Tennessee Prison for Women. In addition, this includes support for the Mailroom imaging stations at 310 Great Circle Road, except for the PC hardware and PC OS.

A.3.20.1.7 <u>EQRO:</u>

A.3.20.1.7.1 Provide data needed for the EQRO contractor.

A.3.20.1.8 <u>Training:</u>

A.3.20.1.8.1 Assure user understanding of system capabilities, providing user support and training, and assist users in the use of the system.

A.3.20.1.8.2 Conduct TCMIS operations training sessions for Bureau personnel or new Facilities Management staff.

A.3.20.1.8.3 Ensure adequate computer capacity during hands-on training sessions so that there is no degradation in performance.

A.3.20.1.8.4 Perform all operational functions related to training as defined by the Bureau.

A.3.20.1.8.5 Provide training to: all identified Bureau staff or other State agencies and affiliates, Bureau contractors, providers, and Contractor staff.

A.3.20.1.8.6 Maintain appropriate hardware, software, and telecommunications to support the development, maintenance, and presentation of training program(s).

A.3.20.1.8.7 Use approved training media including, but not limited to, teleconferencing, web-based and computer-based training.

A.3.20.1.8.8 Training staff shall have the skills necessary to effectively perform training responsibilities including developing, implementing, and maintaining training materials.

A.3.20.1.8.9 Maintain all training materials to reflect the latest version of the TCMIS and current TennCare medical assistance programs policies.

A.3.20.1.8.10 Provide original and updated training plans and training materials to the Bureau for review, feedback, comments, and approval.

A.3.20.1.8.11 Produce, maintain and distribute training materials as specified by the Bureau.

A.3.20.1.8.12 Ensure the training material addresses the specific job functions of the persons being trained.

A.3.20.1.8.13 Highly knowledgeable staff shall conduct training for new and ongoing Bureau and Contractor employees on Contractor and Bureau procedures. Included shall be, at a minimum: how to access and interpret the online screens; how to access and read the reports including detail field information; claims and encounter billing; adjustment processing; encounter enrollment; eligibility; proper provider billing; financial and premium processes; how to read the remittance advices; testing procedures including migration from Model Office to UAT to Production; and other processes utilized for TennCare.

A.3.20.1.8.14 The knowledge transfer training shall apply for all new Contractor personnel.

A.3.20.1.9 <u>Forms Management:</u>

A.3.20.1.9.1 The Contractor shall provide and maintain, at all times, an inventory of all forms that shall meet all mailing and distribution requirements of the Bureau related to this Contract. In addition, the Contractor shall provide and maintain a ninety (90) day supply of all forms throughout the Contract term. The Contractor shall be responsible for providing and maintaining an adequate inventory of all forms and supplies to be available for use on the date that Facilities Manager operations begin. In addition, the Contractor shall provide a ninety (90) day inventory of all forms and supplies available for turnover to the Bureau or its designee on the ending date of this Contract.

A.3.20.1.9.2 The Contractor shall provide and maintain the flexibility throughout this Contract, to modify the content or format of any form or document used or produced by the TCMIS and to develop and produce any other forms required by the Bureau. All changes shall be made at the direction of and be approved by the Bureau. The Contractor shall consider this requirement when determining the level of inventories to be maintained.

A.3.20.1.9.3 Provide all forms related to TennCare including, but not limited to: claims, adjustment requests, recipient ID cards, file maintenance forms, and internal control forms and logs.

A.3.20.1.10 Systems Maintenance:

A.3.20.1.10.1 Perform the activities necessary to correct a deficiency within the operational TCMIS. A system deficiency may be defined as a condition in which the system is not performing up to standard business practices, not performing up to Bureau expectations, or not performing correctly.

A.3.20.1.10.2 Perform activities necessary to ensure that the system continues to meet CMS certification requirements.

A.3.20.1.10.3 Perform activities necessary to ensure that all data files, programs, and documentation are current and errors are found and corrected.

A.3.20.1.10.4 Perform file maintenance activities for updates to all files, as directed by the Bureau.

A.3.20.1.10.5 Submit and verify changes to system parameters.

A.3.20.1.10.6 Make changes to job control language (JCL)/scripts, as directed by the Bureau.

A.3.20.1.10.7 Perform addition of new valid values or changes to existing valid values found within program tables and update the reference guide.

A.3.20.1.10.8 Test, coordinate, and perform changes to application software resulting from any changes in hardware, system software, or designed to improve efficiency of the system. Such improvements may be based on technological changes and security or policy requirements. These changes shall be identified, coordinated with the Bureau, and prioritized within the normal maintenance workload.

A.3.20.1.10.9 Coordinate any systems maintenance activities with other interface entities if needed (e.g., DHS, MedStat, and EQRO).

A.3.20.1.10.10 Coordinate system changes necessary to maintain accurate data exchanges and file builds/construction and to implement new federal/State regulations, as directed by the Bureau.

A.3.20.1.11 User Support:

A.3.20.1.11.1 Provide health care and system consultants to provide assistance with all user aspects of the TCMIS.

A.3.20.1.11.2 Provide analytical and technical support to all Bureau users.

A.3.20.1.11.3 Serve as a liaison with the TCMIS operations staff.

A.3.20.1.11.4 Provide ongoing training to TCMIS users.

A.3.20.1.11.5 Implement a process to initiate, prioritize, track, and document activities of the user support staff.

A.3.20.1.12 Courier Service:

A.3.20.1.12.1 The Contractor shall provide courier services as necessary to perform the duties and responsibilities seven (7) days/week as described in this Contract. This service shall begin early during the transition to ensure timely delivery, if necessary, of test data to the Bureau or other Bureau-designated personnel. This service shall include delivery of documents and materials to and from locations in the Nashville area designated by the Bureau. The Bureau may require that there be up to five (5) pick-ups/deliveries daily, if needed.

A.3.20.1.13 Management Support:

A.3.20.1.13.1 Perform all other activities not otherwise designated as Bureau responsibilities, which are necessary for the operation and maintenance of the TCMIS including scheduling and maintaining regular executive leadership meetings between the Bureau's leadership and the Contractor's corporate executive staff during the execution of this Contract.

A.3.20.1.14 Special Project Support:

A.3.20.1.14.1 For projects that have an expected duration beyond six (6) months, additional staffing and management shall be required. The Bureau shall coordinate with the Contractor to procure additional funding approval.

A.3.20.1.15 Documentation:

A.3.20.1.15.1 Identify necessary modifications to manual and automated processes when operating the TCMIS. Revise operating procedures as required.

A.3.20.1.15.2 The Contractor shall prepare updates to the interChange TCMIS Systems Documentation incorporating all changes, corrections, or enhancements to the TCMIS. Updates to the TCMIS Systems Documentation shall be delivered to the Bureau within ten (10) business days of Bureau approval of implementation of the change, unless otherwise agreed to by the Bureau.

A.3.20.1.15.3 Maintain System Documentation, Mapping Documents and the Data Dictionary.

A.3.20.1.15.4 Support the central repository and document management tool(s) that captures, stores and indexes documentation received by both the Bureau and the Contractor.

A.3.20.1.15.5 Operate the document management component of the interChange TCMIS, including improvements/enhancements as they are implemented.

A.3.20.1.15.6 Support the document management components including: imaging and scanning, workflow management, correspondence management, and reports management. This also includes supporting

other integrated components such as email applications and facsimile transactions performed within the CTS and Recognition Research Imaging (RRI) components.

A.3.20.1.16 Staffing:

A.3.20.1.16.1 Ensure that operations personnel are accessible to Bureau personnel, Monday through Friday from 8:00 a.m. to 5:00 p.m. CT. This includes all regularly scheduled Bureau employee business days. Additionally, ensure that these personnel are also available with reasonable prior notice after 5:00 p.m. CT Monday through Friday and on weekends. Production control personnel shall be accessible twenty-four (24) hours per day, seven (7) days per week.

A.3.20.1.16.2 Provide to the Bureau reasonable access to key Contractor personnel for discussion of problems or concerns.

A.3.20.1.16.3 Provide staff to correct system problems and to support the resolution of discrepancies. This shall include all maintenance activities necessary to ensure the continued efficiency of the TCMIS.

A.3.20.1.16.4 Maintain the TCMIS systems and provide operational support. Operational support involves all processes necessary to meet the requirements outlined throughout this Contract. The Contractor shall perform all maintenance and support as routine activity during the Contract operations at no additional cost to the Bureau. The Contractor shall provide sufficient technical staff to perform all routine systems maintenance responsibilities.

A.3.20.1.16.5 Provide qualified staff readily available to support modification task activities following Bureau approval of work on change requests. It is the Bureau's expectation that all modification activity shall be accomplished within the budgeted effort and that all hours of modification work shall be expended each Contract year. Hours used in excess of the annual allocation may be credited to any previous year's unused balance or secured through execution of an amendment to this Contract. Hours remaining shall be carried forward to the next Contract year.

A.3.20.1.16.6 Designate one (1) primary and at least one (1) secondary person responsible for security.

A.3.20.1.16.7 Provide personnel with the required analytical and processing experience to competently meet the requirements to support normal business analyst functions. Included shall be competency levels specifically relating to MMIS or healthcare adjudicated claims processing experience, specific knowledge, experience, and expertise to perform assigned tasks, and the required technical skills and experience necessary to competently perform and support the maintenance and modification of the TCMIS.

A.3.20.1.16.8 Provide staffing requirements that allow accurate and timely performance of assigned tasks. Included shall be the number of staff

and the technical competency required as well as the relevancy of the experience.

A.3.20.1.16.9 Provide staffing transfer organization chart for Bureau review and approval. Staffing commitments shall not be changed without the prior approval of the Bureau, including reducing the numbers, altering the distribution, or replacing staff. When the Bureau approves staff transfer, included shall be specific cross-training to ensure proficiency of the replacement staff.

A.3.20.1.16.10 Maintain staffing requirements to ensure performance standards are met throughout the term of this Contract.

A.3.20.1.16.11 The Bureau shall monitor and determine the appropriateness and usage of project personnel and whether the staffing complement in this function needs to be changed. The Bureau reserves the right to reject any staff that do not adequately support the duties of their positions.

A.3.20.1.16.12 Provide the necessary staffing requirements specific to the maintenance and modifications tasks. Included shall be the number of staff and the technical and business competency required to meet the requirements of the work requests (or systems change requests) and performance criteria in a timely manner.

A.3.20.1.16.13 Provide the necessary dedicated onsite Medicaid-knowledgeable staff with specific knowledge of their assigned tasks to facilitate communication needed to efficiently resolve the maintenance and modification work. Included shall be the originator of the request and the Contractor personnel assigned to resolve and provide the test results for the request.

A.3.20.1.16.14 Provide the necessary number of dedicated onsite Medicaid knowledgeable staff with specific knowledge of their assigned tasks and with the required technical skills and experience necessary to efficiently and accurately perform the maintenance and modification and work requests.

A.3.20.1.16.15 Provide personnel with the required technical experience and skills necessary to competently perform and support the technical direction, infrastructure, and hardware integration for the TCMIS, coordinating with the State Office for Information Resources.

A.3.20.1.16.16 Provide staff for customer/provider relations functions.

A.3.20.1.16.17 Provide Mailroom staff.

A.3.20.1.17 <u>Testing:</u>

A.3.20.1.17.1 Operate and maintain a complete online TCMIS test system, including, but not limited to: a test version of all batch, interactive, and online programs and test files, Oracle reporting, and Oracle Financials/Premium Process.

A.3.20.1.17.2 Test cases shall include the specific situation that created the problem, additional "real life scenarios", and predefined test cases to include all claim types and edits.

A.3.20.1.17.3 Testing shall be comprehensive and include full system, integration, volume, regression, and parallel testing. All test results shall be repeatable and shall be reviewed by the Contractor for completeness and accuracy before delivery to the Bureau.

A.3.20.1.17.4 Support the user acceptance test facility that allows the Bureau and the Contractor to monitor the accuracy of the TCMIS and test proposed changes to the system by processing test claims and other transactions through the test system.

A.3.20.1.17.5 Operate and maintain a testing facility that simulates a production environment. This environment shall include all subsystems (such as provider, enrollee, reference, claims/encounter claims and TPL) and the data necessary to support all TCMIS processing and reporting functions.

A.3.20.1.17.6 Provide controls to maintain the integrity of the test data.

A.3.20.1.17.7 Provide the Bureau with online access to the testing environments.

A.3.20.1.17.8 Review, validate, and submit for Bureau approval output produced from the test environment.

A.3.20.1.17.9 Deliver all test results to Bureau staff or other Bureau-designated personnel.

A.3.20.1.17.10 Conduct walk-throughs of test results with the Bureau, when requested.

A.3.20.1.17.11 Report on the impact of test cycles and compare those results to the actual processing results.

A.3.20.1.17.12 Keep all test outputs separate from routine TCMIS outputs, and clearly label all outputs as test outputs.

A.3.20.1.17.13 Produce and review all control reports generated for each test update and processing cycle.

A.3.20.1.17.14 Develop test data, including, but not limited to, claims data, at the direction of the Bureau. The testing processes shall include all forms of data submission, (e.g., interactive, batch, data entry).

A.3.20.1.17.15 Perform comprehensive analysis and testing processes that are consistent, including the development and implementation of a Bureau approved Test Plan.

A.3.20.1.17.16 The Test Plan shall include, at a minimum, the following:

A Test Plan and schedule for each unit, module, and subsystem; including any integrated system testing as required;

A description of all test situations and all expected test results;

A comparison process for the test results, including tracking of all discrepancies;

Procedures for updating documentation impacted;

Quality Control review prior to presentation to the Bureau for review;

Processes for corrective actions required; and

Migration procedures for implementation into production.

A.3.20.1.17.17 Document all test results and changes required.

A.3.20.1.18 Certification/Recertification:

The current TCMIS has been certified by CMS. In the event that CMS requires a recertification, the Contractor shall perform all activities needed to meet all certification requirements.

A.3.20.1.18.1 Ensure that the TCMIS meets federal certification requirements defined in the most current version of Part 11 of the State Medicaid Manual. The systems documentation finalized by the Contractor shall be used to support the certification process.

A.3.20.1.18.2 Participate in certification planning, and prepare review materials to demonstrate system compliance with certification criteria.

A.3.20.1.18.3 Assist the Bureau in developing presentation materials.

A.3.20.1.18.4 Provide copies of all system outputs needed to demonstrate full functionality back to the start of operations.

A.3.20.1.18.5 Participate, as necessary, during the federal on-site certification review.

A.3.20.1.18.6 Assist the Bureau in locating material needed to answer review team questions.

A.3.20.1.18.7 Provide any additional materials needed to resolve any post-review corrective actions.

A.3.20.1.18.8 Retain Operations Phase staff to provide post-implementation support during the initial months of operations through certification.

A.3.20.1.18.9 Monitor the performance of the TCMIS during the initial months of operations.

A.3.20.1.18.10 Modify the TCMIS, as needed, to resolve problems identified during the initial months of operations.

A.3.20.1.18.11 Resolve any and all corrective actions needed to finalize federal certification , with Bureau approval.

A.3.20.1.19 Security:

A.3.20.1.19.1 Ensure that all procedures and practices exempt from the open records laws are fully secure and protected.

A.3.20.1.19.2 Ensure that all activities covered by this Contract result in a TCMIS and operational environment that is secure, available and

dependable. The Bureau and the Contractor shall establish a joint security management team to accomplish these objectives.

A.3.20.1.19.3 Treat all information obtained through Contractor performance under this Contract as confidential information and not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securing of its rights, or as otherwise provided herein, as required by federal and State laws, regulations, and policies. State or federal officials, or representatives of these parties as authorized by federal law or regulations, shall have access to all confidential information in accordance with the requirements of State and federal laws and regulations. The Bureau shall have absolute authority to determine if and when any other party is allowed to access TCMIS confidential information.

A.3.20.1.19.4 Provide complete control and accounting of all data received, stored, used or transmitted by the Contractor for the TCMIS to assure administrative, physical, and technical security of the data.

A.3.20.1.19.5 Provide the capability to maintain password control, in varying levels of security, of staff making changes to data. Prevent unauthorized access or modifications to data and comply with all federal and State privacy and security laws, regulations, and policies.

A.3.20.1.19.6 Develop and follow predefined criteria and procedures for overriding system procedures as required, maintaining an audit trail to include a unique identifying number, date, time, and reason for the override.

A.3.20.1.20 <u>Change Management/Software Configuration Management:</u>

A.3.20.1.20.1 Participate in the design and system specifications for enhancements, modifications or changes to the system.

A.3.20.1.20.2 Utilize the Bureau's TeamTrack System and assign a unique identifying number to provide Bureau management with a means of monitoring SCRs.

A.3.20.1.20.3 Utilize the Bureau's TeamTrack System and assign a unique identifying number to provide Bureau management with a means of monitoring Work Requests.

A.3.20.1.20.4 Ensure accurate and thorough testing of system maintenance and Work Requests.

A.3.20.1.20.5 Review test findings, participate in the design and system specifications of additional research and/or testing, and review final product prior to production.

A.3.20.1.20.6 The Contractor shall use the State provided build management tools upon implementation of Enhancement #6...

A.3.20.1.20.7 Ensure technical security for software to ensure authorized access for modifications.

A.3.20.1.20.8 Define procedures for updating software and documentation, including reports to confirm the successful transfer of data and installation of required software.

A.3.20.1.20.9 Utilize migration procedures for implementation into production, including operating instructions, and all documentation and manuals needed to operate and maintain the system.

A.3.20.1.20.10 Change Control: Support and schedule changes to include, at a minimum, the following:

Manage change releases to not interfere with normal TCMIS functionality.

Updating system and user documentation within a timeframe to be determined by the Bureau.

Update provider manuals and training manuals prior to the release of a change into production.

Create and maintain change control process documentation.

Utilize Bureau defined types of changes.

Utilize Bureau defined prioritization process.

Utilize Bureau approval process.

A.3.20.1.20.11 The Contractor shall use the Bureau's TeamTrack system for documenting all change requests. Additionally the Contractor shall coordinate with the Bureau to maintain the TeamTrack software and the data accessed by the software.

A.3.20.1.20.12 Provide regular reports to the Bureau to document the progress of all SCR and work request activities, include monitoring of estimated hours to actual hours.

A.3.20.1.20.13 Verify the accuracy of all software modifications prior to Bureau review.

A.3.20.1.20.14 Ensure a mechanism that eliminates the potential for problems with version control when testing software, procedures for deliverable standards, deliverable version control, and deliverable quality assurance reviews.

A.3.20.1.20.15 Provide approach to deployment, using State standard build management tools.

A.3.20.1.20.16 Provide capability and procedures to allow for multiple software modifications concurrently to include, at a minimum, the following:

a) Ensure that all libraries containing code, data, and software components utilized for testing shall be separate and distinct in all cases from those in production;

b) Ensure a multiple test environment to allow for different phases of testing to be conducted concurrently;

c) Ensure accurate and thorough testing of modifications and System Change Requests;

d) When necessary, link to a particular project and associate multiple existing projects; and

e) Utilize migration procedures for moving multiple projects into production involving common software modules;

A.3.20.1.20.17 The Contractor shall document and have well defined procedures that are consistent with industry and State standards for the following:

a) Version Manager is the source code repository and version control tool that assigns version numbers, controls check-in and check-out, and automates code promotion including branching and merging.

b) Builder is the State standard build management tool that automates the build process. Interacting with Version Manager, it determines which objects have changed since the last build, and also determines which version to put into the build using build log and build audit.

c) Release management including release log, release notes and release schedules.

d) Change management tools for change tracking.

A.3.20.1.20.18 The Contractor shall utilize industry and State standard release management tools that should produce release logs, release notes and release schedules.

A.3.20.1.20.19 Release Management shall include documentation of the release process.

A.3.20.1.20.20 Release Management shall include documentation of an emergency release process.

A.3.20.1.20.21 The Contractor shall review the system audit trail to ensure accurately promoting modified software for multiple projects.

A.3.20.1.20.22 The Contractor shall follow industry and the State's standard processes for version management to include, but not be limited to, check in/ out controls, branching, merging, and version control tools.

A.3.20.1.21 Quality Control:

A.3.20.1.21.1 Provide a Quality Control Plan that ensures that each functional and system component shall have quality control reviews.

A.3.20.1.21.2 Report the findings for each of these quality control activities to the Bureau with a Corrective Action Plan.

A.3.20.1.21.3 Follow-up review to make certain the problem is resolved, if applicable.

A.3.20.1.21.4 The Contractor shall inform the Bureau within one (1) hour of its awareness of any significant implementation or operational problem.

A.3.20.1.21.5 The Contractor shall submit a CAP to the Bureau within ten (10) working days from notification of an area identified as being out of compliance with Contractor responsibilities.

A.3.20.1.21.6 The Contractor shall successfully carry out the Bureau approved CAP within the time frames outlined in the CAP.

A.3.20.1.21.7 Provide a Quality Control Plan that ensures accurate testing of maintenance and modification in accordance with the Bureau-approved processes and procedures and ensure the quality control procedures are followed and reported.

A.3.20.1.21.8 Provide ability to maintain flexibility in coding structures by the use of parameter and table oriented design techniques to enable rapid and efficient software modification, allowing for multiple modifications to be made concurrently.

A.3.20.1.21.9 Ensure the Quality Control Plan is efficient, effective, and performed according to the timelines as required by the Bureau or the business needs of the user.

A.3.20.2 Information Management:

The Bureau has embarked on building an Information Management System that shall achieve the following goals:

Provide timely and accurate processing to support customer service for recipients and stakeholders

Provide convenient and timely access to information

Perform automated tasks

Grant access to critical documents, online, by authorized users

Support data analysis and report capabilities.

The Information Management System includes document imaging, storage and retrieval features and functions, and includes the following:

A Computerized Telephony System (CTS) for call management and monitoring

Document imaging, storage and retrieval

Processes to increase efficiency, accuracy and overall effectiveness of recipient care.

A.3.20.2.1 Computerized Telephony System - CTS

Fast and accurate customer service is imperative to resolve problems and answer questions for TennCare recipients. The Bureau has provided its enrollees the ability to contact the Bureau and access information through the use of an automated call management system.

The Bureau has two (2) Contact Centers that handle inbound calls to address recipient and applicant inquiries, as well as receiving appeals over the telephone. The Computer Telephony System (CTS) provides call routing so that specific calls are routed to the agent best trained to handle that call. Screen “pops” display recipient demographic information (e.g., name, address, telephone number and social security number), based upon the gathering and matching of

information the recipient provides. This ensures a complete picture of the recipient's interaction history with the Bureau. This design increases effectiveness in handling issues while improving efficiency.

The Computerized Telephony System-AVAYA Enterprise Manager (CTS-AEM) solution includes a telephony system that will route recipient calls to a Member Services Customer Services Representative (CSR) and handle multiple types of calls. Call types have been defined by the Member Services departments and are tracked as follows:

Request for Information

Need to change information

Eligibility redetermination

Question about letter I received in the mail

I did not get my letter (appeal type)

Why was my TennCare terminated

Request for a refund or question about your refund

Status of appeal

I want to file an appeal

MCO is not paying claims

MCO Assignment

Additional Insurance (TPL)

Medicare

MCO Complaints

A.3.20.2.2 Document Imaging, Storage and Retrieval

The Document Imaging System supports the activities and workflows of TCMIS users by providing access to electronic versions of documents and reports. Document Imaging provides a central image repository for incoming and outgoing faxes, emails, claims, correspondence, and supporting documentation. It facilitates the routing, review, and sharing of documents among a large user group without the risk of paper loss or destruction.

The Document Imaging System is divided into four (4) functional processes which are:

1) The Document and Imaging System first requires all designated items to be imaged using RRI software.

2) The Document Imaging Capture process includes the gathering of scanned documents (claims and correspondence), electronic faxes, management reports, select emails, outgoing letters and statements, and other document attachments.

3) The Document Imaging Storage process encompasses the retention of captured documents and reports to provide viewing access and archival capabilities for all stored information.

4) The Document Imaging Retrieval process provides end-user viewing capabilities for the stored electronic documents and reports.

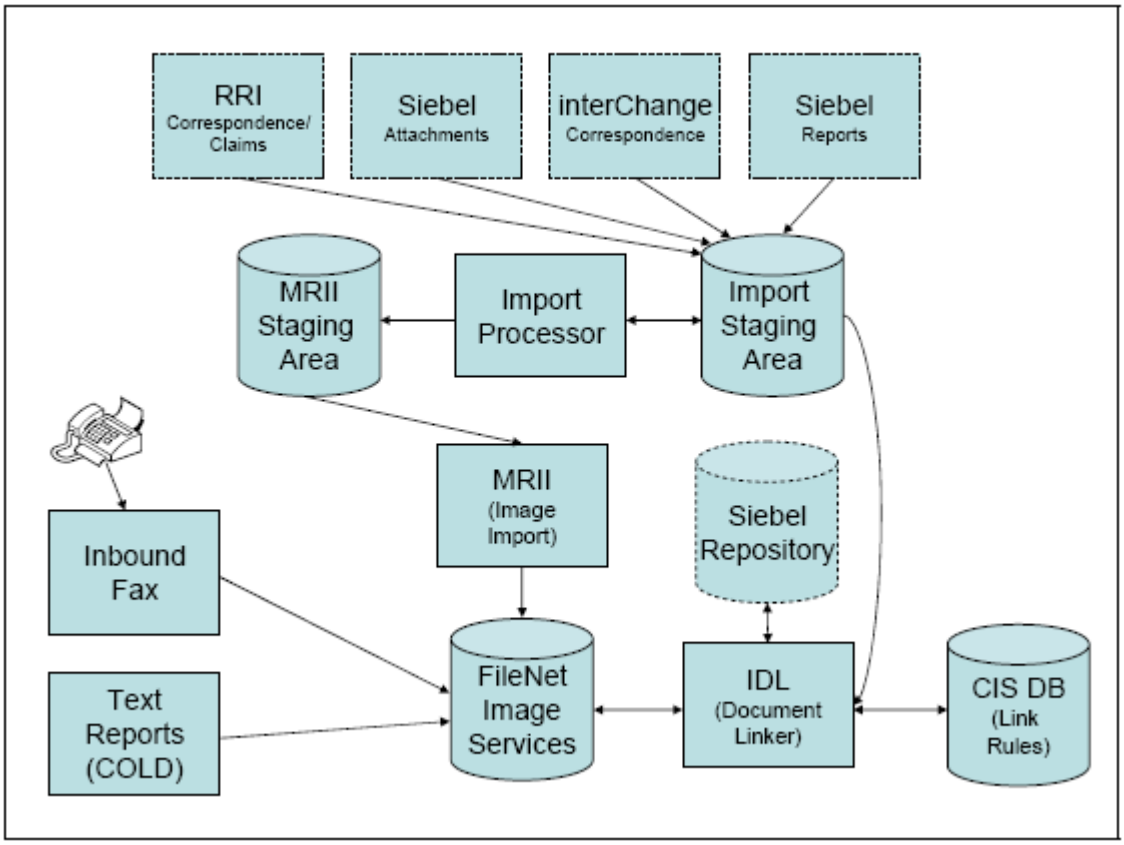
A.3.20.2.3 Document Imaging, Storage and Retrieval Contractor Requirements:

A.3.20.2.3.1 Maintain one hundred percent (100%) accuracy for all data entry fields, all scanning, and all imaging,

A.3.20.2.3.2 Provide a Quality Assurance Plan to ensure data entry, scanning, and imaging have quality control reviews. Included shall be a method for reporting the findings for each of the quality control activities to the Bureau, a Corrective Action Plan, and a follow-up review to make certain the problem is resolved, if needed.

A.3.20.2.3.3 Imaging Design Diagram:

This diagram depicts the design of imaging software interfaces. The Contractor shall be expected to maintain the software needed for imaging.



A.3.20.3 Non-Production Server Support

A.3.20.3.1 Non-Production Server Support Contractor Requirements:

A.3.20.3.1.1 Support all hardware operations and system administration of the non-production Sun and Dell Servers, including maintaining the operating systems, hardware, software patch levels, and antivirus protection levels, including support for related network switches.

A.3.20.3.1.2 Manage backup of non-production Servers located at Bureau offices and coordinate off-site storage.

A.3.20.3.1.3 Manage restore of data from backup when necessary.

A.3.20.3.1.4 Management of data storage at the Bureau location.

A.3.20.3.1.5 Management of data storage at other locations if not at Bureau location.

A.3.20.3.1.6 Respond to Network Operations and Security Center (NOSC) alarms/alerts for all identified Servers.

A.3.20.3.1.7 Support Hot Site Disaster Recovery testing for operating environment, both hardware and software (HW/SW).

A.3.20.3.1.8 Management of connectivity to integrate the activities of the Servers where required for operations.

A.3.20.3.1.9 Provide support for infrastructure database of all TCMIS assets and support contact information for the OIR Help Desk and Data Center.

A.3.20.3.1.10 The Contractor shall prepare the supported Servers for moving to any new Bureau building location and reinstalling the Servers in the new location, if deemed necessary by the Bureau. Movement of any of the Servers to a different location shall not affect the terms of this Section of this Contract. The State and the Contractor shall negotiate the terms of the Server support should there be a significant increase or reduction in the number of Servers supported.

A.3.20.4 <u>Production Server Support</u>

A.3.20.4.1 Production Server Support Contractor Requirements:

A.3.20.4.1.1 Support hardware operations and system administration of RRI, NICE, Siebel T-Servers, AEM and AVRS intervoice Servers including maintaining the operation systems, hardware and software patch levels.

A.3.20.4.1.2 Manage backup of the production Servers at Bureau location included in the IM implementation footprint Servers and coordinate offsite storage.

A.3.20.4.1.3 Manage restore of data from backup when necessary.

A.3.20.4.1.4 Management of data storage at other locations if not at Bureau location.

A.3.20.4.1.5 Management of data storage at Bureau location.

A.3.20.4.1.6 Respond to Network Operations and Security Center (NOSC) alarms/alerts for all identified Servers.

A.3.20.4.1.7 Contractor's staff shall support Hot Site Disaster Recovery testing for operating environment - HW/SW.

A.3.20.4.1.8 Contractor's staff shall support scanners and Interfaces hardware to Scan-stations.

A.3.20.4.1.9 Manage connectivity to integrate the activities of the Servers where required for operations.

A.3.20.5 Suspense Processing Support

A.3.20.5.1 Suspense Processing Support Contractor Requirements:

A.3.20.5.1.1 Develop and maintain a comprehensive Claims Adjudication Manual for approval by the Bureau.

A.3.20.5.1.2 Establish and maintain appropriate Bureau review, approval and sign-off procedures for claims within the Contractor's responsibility. Contractor shall maintain Claims Adjudication Manual for claims within Contractor's responsibility to ensure procedures meet the intent of Bureau policies and/or rules.

A.3.20.5.1.3 Establish and maintain production standards.

A.3.20.5.1.4 Identify, hire, and maintain staff based on ongoing suspense level projections of eight thousand, one hundred (8,100) suspended claims per week. Although this is the projected suspended claims volume, the Contractor shall allow for volume fluctuation up to twenty thousand (20,000) claims per week.

A.3.20.5.1.5 Develop and maintain training for the staff to include plans for cross-training resolution staff in all edits and audits.

A.3.20.5.1.6 Establish and maintain facility and infrastructure requirements to accommodate a centralized organization for resolution of claims.

A.3.20.5.1.7 Maintain reporting of claims processing metrics for monthly status reporting to the Bureau Business Owner.

A.3.20.5.1.8 Serve as liaison in managing claims adjudication with the Bureau's Business Unit responsible for claims processing, the Contractor's project manager and system team leader responsible for claims processing.

A.3.20.5.1.9 Participate in change management activities to ensure procedures and processes are updated when system or policy changes are implemented.

A.3.20.5.1.10 Provide regular reporting of status to Bureau Business User.

A.3.20.5.1.11 Schedule work for suspense resolution staff for production claims to ensure that they are resolved to completion each week.

A.3.20.5.1.12 Maintain Suspense Processing Performance Standards:

A.3.20.5.2 Complete processing of all Suspense receipts received within the Contractors responsibility promptly, such that the aggregate fee-for-service claims timeliness are within the prompt pay standards set by CMS: Ninety Percent (90%) of all

clean claims will be paid or denied within thirty (30) days of receipt. Ninety-nine Percent (99%) of all clean claims will be paid or denied within ninety (90) days of receipt.

Complete any transitioned backlog of suspended claims within the mutually agreed upon timetable by the Bureau and Contractor.

A.3.20.6 Member Services

A.3.20.6.1 Member Services Contractor Requirements:

A.3.20.6.1.1 Maintain the Computerized Telephony System (CTS) and the integration with the TCMIS to support call management and history tracking.

A.3.20.6.1.2 Support the integrated Correspondence Management component.

A.3.20.6.1.3 Support the Document Imaging component of the TCMIS infrastructure.

A.3.20.6.1.4 Record and track contacts and maintain a history file of contacts, including telephone calls and written documents (incoming and outgoing), and allow authorized users to have access to this information.

A.3.20.6.1.5 Maintain the functionality of the integrated TCMIS call management system and record the date, phone number (caller ID), and Customer Service Representative (CSR) taking the call.

A.3.20.6.1.6 Maintain functionality to retrieve, recall, record, and be able to view all comments (telephone and written notes) relating to the enrollee's call.

A.3.20.6.1.7 Maintain functionality to generate an audit trail and identify the CSR who responded to the call.

A.3.20.6.1.8 Maintain functionality to allow authorized users to automatically generate correspondence using "template" letters and forms online. Retain electronic copies and allow online accessibility.

A.3.20.6.1.9 Maintain multiple address lines and multiple addresses (denoting the source and date of each) and track who called, when, and why a change was made to the address and allow the change to be made online during the call.

A.3.20.6.1.10 Maintain functionality to initiate workflow assignments, generate reminders and tickler alerts, and produce management reports for the Member Services Supervisors.

A.3.20.6.1.11 Maintain AVRS functionality.

A.3.20.6.1.12 Maintain indicator to identify if an enrollee has an appeal in process to keep eligibility from closing during the appeal process.

A.3.20.6.1.13 Maintain imaging capability to image incoming documents and correspondence.

A.3.20.6.1.14 Maintain imaging capability to electronically store all outgoing correspondence.

A.3.20.6.1.15 Maintain functionality to store and aggregate all inquiries/correspondence within the enrollee's record. The data shall be accessible to all authorized entities.

A.3.20.6.1.16 Maintain functionality to provide "help screens" and instant messaging (automated message board) capabilities to assist CSR in responding to inquiries.

A.3.20.6.1.17 Maintain edits into the call-tracking system to ensure consistency and validity of information received through online data entry and file maintenance.

A.3.20.6.1.18 Maintain update functionality of enrollee data (e.g., address, phone number).

A.3.20.6.1.19 Maintain functionality to produce standard notices, forms, letters and reports within one (1) business day of request by the user.

A.3.20.6.1.20 Maintain CTS information on TCMIS Member Services component to document each contact (telephonic, facsimile, written or electronic) with a TennCare enrollee or designee.

A.3.20.6.1.21 Maintain functionality to image all written correspondence received by Member Services and retain in the appropriate enrollee's file with appropriate links to enrollee data.

A.3.20.6.1.22 Maintain appeals transaction records to track and trend all Administrative Appeals received by DHS.

A.3.20.6.1.23 Operate and maintain the processes needed by the Member Services component of the TCMIS, complying with systems requirements for the Correspondence Management and Document Imaging Components.

A.3.20.6.1.24 Produce and distribute the Monthly Member Services Utilization Report documenting all member services contacts.

A.3.20.6.1.25 Maintain and operate an adequate system of internal controls to safeguard access to information.

A.3.20.6.1.26 Provide accessibility to outputs and files as specified by the Bureau.

A.3.20.6.1.27 Provide the Bureau with necessary information (data and reports) to satisfy audits and other reporting requirements.

A.3.20.6.1.28 Deliver and pick up mail for distribution/delivery twice daily.

A.3.20.6.1.29 Make the Member Services component of the CTS available to Bureau staff or designee twenty-four (24) hours per day, seven (7) days per week.

The Contractor shall respond to Level Two requests for support within the stated guideline on at least ninety-nine percent (99%) of the requests. Response is defined as a contact with the user either through an in-person visit, a telephone conversation, a voicemail message, or an email.

The table below depicts the required response times:

Level	Response Time in business hours
Two	24 hours
Three	4 hours

Upon notice of a deficiency by the State, the Contractor shall propose a Corrective Action Plan (CAP) to remedy said deficiency. If the Contractor fails to complete the mutually agreed upon CAP, liquidated damages may be assessed at a rate of ten dollars ($10.00) per request for each request not responded to within the ninety-nine percent (99%) threshold within the Level Two and Level Three categories up to a maximum of five hundred dollars ($500) per month.

A.3.20.7 Information System Bureau Responsibilities – Operations:

A.3.20.7.1 Approve Contractor procedures and schedules for payment information distribution.

A.3.20.7.2 Review inventory management, other operational claims reports, and financial reports from the Contractor.

A.3.20.7.3 Provide at least three (3) business days notice to the Contractor prior to requiring the processing of any payment cycle in addition to the normal weekly payment cycles.

A.3.20.7.4 Monitor payment cycles and notify the Contractor of any apparent discrepancies.

A.3.20.7.5 The Bureau shall review and approve all modification and other work estimates involving the modification staff.

A.3.20.7.6 Prepare and submit the necessary financial documents to the Office of the Comptroller of the Treasury to allow payments from each payment cycle to be released to providers and contractors.

A.3.20.7.7 The Bureau shall establish a method for setting priorities that consolidates and categorizes requests based on agreed upon criteria (e.g., federal requirements, auditor issue, dollar impact), to include all functional impacts. This review shall include a business analyst, a business user, and a liaison to analyze the requests. Requests that have been outstanding for a pre-determined period of time shall be re-reviewed for necessity and possible grouping, to ensure the resolution of minor and low priority requests. Operational incidents, emergency requests, and long term projects shall also be reviewed and prioritized in this process for more effective scheduling and efficient use of resources

A.3.20.8 Customer Service Bureau Responsibilities:

A.3.20.8.1 Ensure that the Contractor provides the functionality to enable Bureau staff to operate a twenty-four (24) hour hotline to respond to inquiries for enrollee information.

A.3.20.8.2 Ensure that the Contractor supported Call Tracking System (CTS) functions in order for Bureau staff to monitor response time (and add CSR staff as needed to ensure a timely response to all calls received).

A.3.20.8.3 Make eligibility, address, and premium updates to the TCMIS following notification from enrollees or their designees or forward updates to the Contractor's file maintenance section.

A.3.20.8.4 Use information maintained in the iC TCMIS to make an administrative review determination decision on each administrative appeal using criteria established by Bureau policy.

A.3.20.8.5 Approve all system-generated forms, letters or correspondence used to communicate with TennCare enrollees or their designees.

A.3.20.9 Computerized Telephony System Bureau Responsibilities:

A.3.20.9.1 Provide the location, space, phone lines with appropriate bandwidth and channels to support the proposed and accepted configuration.

A.3.20.9.2 Operate and maintain the CTS according to manufacturer specifications.

A.3.20.9.3 Assist the Contractor with TCMIS integration requirements.

A.3.20.10 Document Imaging, Storage, and Retrieval Bureau Responsibilities:

A.3.20.10.1 Review and approve the installation, testing and operational plan.

A.3.20.10.2 Participate in acceptance testing/approve Acceptance Test.

A.3.20.10.3 Implement workflow process reengineering recommendations and plans.

A.3.20.10.4 Route documents for scanning, imaging and indexing.

A.3.20.11 Information Management Contractor Requirements:

A.3.20.11.1.1 Provide capability to scan, store and retrieve a permanent image of all correspondence, received and sent in a digitized image for a period of five (5) years.

A.3.20.11.1.2 Provide access to complaint, grievance and appeals records, including history and status information.

A.3.20.11.1.3 Maintain electronic transaction processing for the following functions: enrollment, eligibility, claims related transactions, encounter data, and coordination of benefits with other payers and carriers, including Medicare crossover claims.

A.3.20.11.1.4 Support requirements for electronic banking, including electronic funds transfer and compliance with the Federal Cash Management Improvement Act.

A.3.20.11.1.5 Support requirements for electronic TennCare Eligibility Verification, including use of Point of Sale (POS) terminal devices, PC based dial-up, host-to-host, and AVRS.

A.3.20.11.1.6 Support requirements for Internet online services and information publishing.

A.3.20.11.1.7 Ensure compliance with HIPAA electronic data interchange (EDI) standards.

A.3.20.11.1.8 Produce and distribute all correspondence, letters and notices within required timelines.

A.3.20.11.1.9 Process all returned mail received from enrollees and providers.

A.3.20.11.1.10 Provide local hardware and software maintenance, with reasonable expected response time for service calls.

A.3.20.11.1.11 Maintain functionality to scan, image, index and route all documents and correspondence received within five (5) days of receipt.

A.3.20.11.1.12 Documents which have failed established indexing standards shall be routed to a designated end user for resolution within twenty-four (24) hours.

A.3.20.11.1.13 Display an image upon retrieval within five (5) seconds if the document(s) resides on a local cache Server and twelve (12) seconds for documents residing on optical disk.

A.3.20.11.1.14 Provide the functionality to support Document Imaging, Storage and Retrieval applications.

A.3.20.11.1.15 Identify, notify the Bureau, and correct all errors and discrepancies found in the operational system. No additional charges for computer resources needed to maintain or correct the system shall be authorized.

A.3.20.11.1.16 Provide TCMIS related software-training sessions for Bureau staff, contractors, and other State agencies as agreed; with the Bureau.

A.3.20.11.1.17 Develop, maintain, and provide access to those records required by the Bureau to monitor all performance requirements and standards, including, but not limited to, reports necessary to show throughput activity, backlogs, data entry backlogs, suspense file status, and other performance items.

A.3.20.11.1.18 Produce all required operations reports, and make available online or deliver to the Bureau within established time frames as currently provided today.

A.3.20.11.1.19 Produce reports and make available online or deliver to the Bureau all required federal and State financial reports within established time frames as currently provided today.

A.3.20.11.1.20 Produce reports necessary for the Bureau to monitor accounts receivable, liens, recoupments, and other financial transactions as currently provided today.

A.3.20.11.1.21 Maintain security for restricted access objects at all times.

A.3.20.11.1.22 Report any security violations security violations immediately to the Bureau.

A.3.20.11.2 Modification of Functionalities Requirement:

The following requirements are functionalities that shall be developed and implemented by the Contractor after Bureau approval.

A.3.20.11.2.1 When MITA becomes implemented, the Contractor shall utilize tools that are flexible and reusable for various functions. MITA architecture standards are based on a modular component design approach that allows for interoperability across components and with external applications and data sources.

A.3.21 Turnover Tasks

The Contractor shall complete all of the tasks and perform all of the services related to turnover set forth in this Contract, according to the State approved work plan, and shall ensure that all of the tasks turned over to the Bureau conform to the requirements set forth in this Contract.

In the event the Contractor fails to turnover to the Bureau or its designee in accordance with the State approved turnover plan, the Contractor shall be liable for all actual costs incurred by the State in converting and/or updating the deficient item(s) into the form/format necessary for use in the certified TCMIS, and in the future amount of any costs the Bureau incurs in securing the operation of the TCMIS, until such time as the deficiency is corrected.

A.3.21.1 Turnover Plan

The Contractor shall create a Turnover Plan for the TCMIS infrastructure and submit the plan no later than one (1) year from the start of full operations of the TCMIS, for Bureau approval. The Turnover Plan shall be updated and re-submitted to the Bureau no later than one (1) year prior to the end of this Contract period for Bureau approval. The updated comprehensive Turnover Plan shall fully address the Contractor's approach to each of the Turnover Tasks in detail for each operational component of the TCMIS.

The Turnover Plan for the TCMIS shall track both the prior Facilities Manager and the Contractor responsibilities, and shall include Turnover work plan documents. The Turnover Plan shall be updated or re-presented at least one (1) year prior to the end date of each optional Contract year, if a Contract extension period is granted. The Turnover Plan shall include a proposed approach to the turnover, a requirements statement, and a schedule including tasks and sub-tasks. The Turnover Plan shall also include all TCMIS production data, program libraries, resource inventory, software, and all associated documentation.

A.3.21.1.1 The Turnover Plan shall include the following deliverables:

A.3.21.1.1.1 Turnover approach;

A.3.21.1.1.2 TCMIS requirement statement;

A.3.21.1.1.3 Resource inventory, including staff, hardware and software that is needed to operate all components of the TCMIS;

A.3.21.1.1.4 TCMIS software and files;

A.3.21.1.1.5 Up-to-date TCMIS System, User , Operations, Procedures, and Training documentation; and

A.3.21.1.1.6 Turnover deliverables (e.g., progress reports, inventories, configuration diagrams)

A.3.21.2 Complete and Correct TCMIS Turnover

A.3.21.2.1 The Contractor shall ensure that the TCMIS shall be error free and complete when turned over to the Bureau or the successor Contractor. If not, the Contractor shall correct, at no cost to the State, any malfunctions that existed in the TCMIS infrastructure prior to turnover or that were caused by lack of support by the Contractor, as may be determined by the Bureau or its designee.

A.3.21.3 Turnover Support

A.3.21.3.1 The Contractor shall provide full support and assistance in the transition of Facilities Manager operations and TCMIS functions to the Bureau, their designee, or the successor Contractor.

A.3.21.3.2 The Contractor shall cooperate with the successor Contractor while providing all required turnover services. This shall include meeting with the successor to ensure that the division of work schedules and responsibilities are agreeable for the Bureau, the current Contractor and the successor Contractor.

A.3.21.3.3 If requested by the Bureau, the Contractor shall transfer any source program code or data files on electronic media.

A.3.21.4 Contractor Responsibilities:

A.3.21.4.1 Staffing Resources

A.3.21.4.1.1 The Contractor shall supply an estimate of the number, type, and salary range of personnel needed to operate the equipment and other functions associated with the operation of the TCMIS infrastructure. This inventory shall be separated by type of activity of the personnel, including but not limited to the following:

Data processing staff

Computer operations staff

Systems analysts

Systems programmers

Database administrators/designers

Programmer analysts

Business analysts

Project management staff

Data entry and imaging operators

Provider services staff

Administrative staff

Trainers

Coordinators

Supply clerks and administrative assistants

Managers

A.3.21.4.1.2The Contractor shall provide a detailed organizational chart depicting the Contractor's total TCMIS operations resources.

A.3.21.4.1.3Turnover Staff Requirements:

The Contractor shall provide the following dedicated staff with appropriate job skills as follows to support turnover activities:

Turnover Manager	At least three (3) years MMIS experience and experience turning over operations similar in size and scope

The Turnover manager may serve part-time until the Bureau initiates a request for the turnover activities to begin, then this person shall devote one-hundred percent (100%) of time to turnover activities until the end of this Contract.

The Contractor shall dedicate special additional resources at no cost to the Bureau to facilitate required turnover activities (e.g., to perform systems corrections where deficiencies exist that are due to lack of Contractor support prior to turnover).

A.3.21.4.2 Turnover Inventory of Operational Resources

The Contractor shall provide an inventory of all facilities and other resources (in the form and format as specified by the Bureau), that is required to operate the TCMIS, including but not limited to:

A.3.21.4.2.1Data processing and imaging equipment;

A.3.21.4.2.2Technical environments used;

A.3.21.4.2.3All testing environments;

A.3.21.4.2.4Applications, environments and functions;

A.3.21.4.2.5System and special software applications;

A.3.21.4.2.6Telecommunications circuits (voice and data);

A.3.21.4.2.7Imaged documents stored on optical and magnetic media;

A.3.21.4.2.8Production or those used as production computer programs;

A.3.21.4.2.9Production scripts, routines, control language and schemas; and

A.3.21.4.2.10 Operations logs, balancing documents, and process summaries.

A.3.21.4.3 Turnover of Documentation

The Contractor shall provide all production documentation in hard and soft copy that is used to maintain and operate the TCMIS, including but not limited to the following:

A.3.21.4.3.1User documentation;

A.3.21.4.3.2Operations documentation;

A.3.21.4.3.3System documentation (e.g., including procedures for updating computer programs);

A.3.21.4.3.4Procedures documentation;

A.3.21.4.3.5Training documentation;

A.3.21.4.3.6Data dictionary;

A.3.21.4.3.7System configuration diagrams; and

A.3.21.4.3.8BCCP and Recovery procedures.

A.3.21.4.4 Turnover Training Activities

A.3.21.4.4.1The Contractor shall provide training to the successor staff in the operation of the TCMIS infrastructure. Such training shall be completed at least six (6) months prior to the end of this Contract. Such training may include, but not be limited to:

Data entry and imaging

Claims processing

Computer operations and production control functions

Controls and balancing procedures

Update procedures

Work-around procedures or processes

Exception claims processing functions

All manual processes and procedures.

A.3.21.4.4.2If required by the Bureau, the Contractor shall provide scheduled, guided visits through facilities management operations.

A.3.21.4.5 Turnover of Work

The Contractor shall turn over all outstanding work according to a schedule as determined by the Bureau. Outstanding work includes, but is not limited to the following:

A.3.21.4.5.1Outstanding/unprocessed paper claims;

A.3.21.4.5.2All paper files;

A.3.21.4.5.3ME applications;

A.3.21.4.5.4 Correspondences (notices);

A.3.21.4.5.5 Returned mail;

A.3.21.4.5.6 TPL Questionnaires;

A.3.21.4.5.7 File maintenance forms;

A.3.21.4.5.8 Financial paper records;

A.3.21.4.5.9 Imaged correspondences;

A.3.21.4.5.10 Written correspondences;

A.3.21.4.5.11 Work in progress: (1) SCR and WR inventory and (2) Other Work Inventory; and

A.3.21.4.5.12 Quality management documents.

A.3.21.4.6 Other Turnover Inventory

A.3.21.4.6.1 The Contractor shall provide a complete inventory of State owned furniture and equipment that shall be turned over to the Bureau at the end of this Contract.

A.3.21.4.6.2 The Contractor shall maintain an inventory of State owned equipment and submit an inventory report to the Bureau monthly, or as required.

A.3.21.4.6.3 Any State owned furniture or equipment not used by the Contractor shall be returned to the State, and reflected in the periodic inventory report.

A.3.21.4.6.4 The Contractor shall identify any State-owned equipment or furniture that is in inventory, but for which its presence is unknown.

A.3.21.5 Bureau Responsibilities:

The Bureau shall be the point of contact during the Turnover activities, and shall work closely with the successor Contractor during the planning of the Turnover Activities.

A.3.21.5.1 Notify the Contractor of the State's intent to transfer or replace the TCMIS at least one (1) year prior to the end of the Contract.

A.3.21.5.2 Review and approve the turnover plan.

A.3.21.5.3 Review and approve turnover schedule.

A.3.21.5.4 Review and approve requirements statement.

A.3.21.5.5 Review and approve the resource inventory which would be required to take over operations of the TCMIS.

A.3.21.5.6 Make State staff or designated staff available to be trained in the operation of the TCMIS.

A.3.21.5.7 Coordinate the transfer of TCMIS documentation (in hard and soft copy formats,

software and data files).

A.3.21.5.8 Review and approve a turnover results report that documents completion of each step of the turnover plan.

A.3.21.5.9 Obtain post turnover support from the Contractor in the event of software malfunction or software deficiencies, and establish a completion date for required corrections.

A.3.21.5.10 Approve the final format and content of all deliverables.

A.3.21.5.11 Determine a schedule in which the current Contractor is to turnover all outstanding work to the successor contractor.

A.3.21.5.12 Specify the form and format for facilities and other resources inventory (refer to Section A.3.21.4.2.).

A.4 Change Management

A.4.1 Maintenance Tasks

There is an existing workload of Work Requests (WRs) that shall continue to be addressed under this Contract term. The Contractor shall be responsible for managing and tracking the WRs. The Contractor shall be responsible for maintaining the TCMIS throughout the term of this Contract. This Section describes how future fixes to the system shall be categorized, the minimum staffing requirements, the milestones that shall be met within task activities, and how Bureau and Contractor responsibilities are defined.

All TCMIS functions shall be updated and maintained by the Contractor according to federal certification requirements, the CMS State Medicaid Manual, all federal mandates, and all State requirements, statutes, and regulations.

A.4.1.1 Maintenance Overview

The Contractor shall perform software maintenance for the component parts of the TCMIS, as directed by the Bureau. It is the Bureau's expectation that all maintenance requirements shall be accomplished under the terms of this Contract's firm fixed price for machine time, person time, documentation support and any other related support.

Maintenance also includes fixes that result from a determination by the Bureau or by the Contractor that a deficiency exists within the operational TCMIS, including deficiencies found after implementation of modifications and enhancements incorporated into the operational TCMIS.

The various types of maintenance support shall include:

A.4.1.1.1 Activities necessary to provide for continuous effective and efficient operation of the system to keep it ready and fit to perform at the standard and condition for that it was approved;

A.4.1.1.2 Activities necessary to ensure that all data, files, and programs are current and that errors are corrected and prevented;

A.4.1.1.3 Activities necessary to meet CMS certification requirements that exist at the time of Contract Start date;

A.4.1.1.4 Activities related to file growth and partitioning;

A.4.1.1.5 File maintenance activities for updates to all files;

A.4.1.1.6 Scheduled ongoing tasks to ensure system tuning, performance, response time, database stability, and processing;

A.4.1.1.7 Changes to the JCL (or JIL), or system parameters concerning the frequency, number, and media of reports or data feeds;

A.4.1.1.8 Updates to software, operating systems or other system components requiring

version updates, manufacturer “patches” and other routine manufacturers’ updates to software;

A.4.1.1.9 Addition of new values and changes to existing system tables and conversion of prior records, as necessary;

A.4.1.1.10 Fixes for something that does not work according to requirements;

A.4.1.1.11 Entry of all system lists, parameters, and other table updates;

A.4.1.1.12 Activities to perform technology (system hardware, software) upgrade refreshment, excluding Enhancement related upgrades

A.4.1.2 System Maintenance Staffing Contractor Requirements:

The Contractor shall provide sufficient staff to perform all systems maintenance responsibilities as included in A.6.3 Maintenance and Modifications. These staff members may be located at the Bureau's site or off site, in accordance with the staff requirements listed in this Contract. The Contractor shall provide monthly reports to the Bureau detailing the activities by task for each of the maintenance staff. The report shall include a summary of hours worked by staff by maintenance task.

A.4.1.3 Maintenance Task Activities

The person identifying the need or potential need for system maintenance shall promptly initiate a Work Request (WR) or System Change Request (SCR) indicating the nature of the maintenance activity required. The Contractor shall follow the Change Order process to work the change request. The Contractor shall make reporting available to the Bureau on the timeliness of the processing of maintenance requests, including the identification of the percent of maintenance requests performed within ten (10) business days. The Contractor shall have the general discretion to assign Maintenance and Modifications staff to maintenance support as required to complete requests timely and will coordinate with the Project Director to address changes in Bureau needs and priorities. The Bureau will perform requirements validation, test validation and post-implementation review of maintenance requests timely so the requests may be closed in the change management tracking tool.

Weekly status meetings shall be held between the Bureau and Contractor. The weekly meetings shall allow the Contractor to report progress against schedules and any necessary schedule revisions, and shall allow for discussion of specific details where necessary. The Contractor shall document these status meetings as meeting minutes.

In addition, the Contractor shall be required to coordinate with the Bureau to use TeamTrack to maintain all work requests and will include all relevant associated information.

A.4.1.4 Maintenance Task Contractor Requirements:

A.4.1.4.1 Provide maintenance resources to perform all maintenance activities necessary to ensure the continued efficiency of the TCMIS.

A.4.1.4.2 Notify Bureau when operational problems occur.

A.4.1.4.3 Submit Work Requests, System Change Requests, or Corrective Action Plans, as appropriate, regarding all deficiencies.

A.4.1.4.4 Perform all activities relative to the correction of deficiencies within the time-frames stated in this Contract.

A.4.1.4.5 Organize and provide status and associated information during periodic status meetings with the appropriate Bureau staff to monitor current operations and to monitor progress of maintenance activities.

A.4.1.4.6 Provide status meeting minutes to the Bureau within two (2) business days after the meeting.

A.4.1.4.7 Provide consultation to the Bureau in the development of maintenance requests.

A.4.1.4.8 Utilize TeamTrack for tracking and reporting of maintenance projects.

A.4.1.4.9 Perform work assignments according to priorities set by the Bureau.

A.4.1.4.10 Correct all errors and discrepancies found in the operational system at no additional charge to the Bureau.

A.4.1.4.11 Receive the notification of discrepancy on a work request from the Bureau.

A.4.1.4.12 Inform the Bureau when a system deficiency is suspected by phone, in-person, email or TeamTrack, within one (1) business day of identification

A.4.1.4.13 Enter the work request identifying the maintenance support into TeamTrack.

A.4.1.4.14 Submit test plan, including testing responsibilities, when required by the Bureau.

A.4.1.4.15 Conduct unit test.

A.4.1.4.16 Conduct systems test in coordination with Bureau staff.

A.4.1.4.17 Present test results to the Bureau.

A.4.1.4.18 Conduct integrated (regression) test in coordination with Bureau staff.

A.4.1.4.19 Prepare, submit, and distribute updates to TCMIS system documentation, user and provider manuals, other user documentation, and any other necessary documentation within ten (10) business days of the date the change goes into production, unless otherwise agreed to by the Bureau.

A.4.1.4.20 Implement Corrective Action plans upon Bureau approval.

A.4.1.4.21 Verify the successful implementation of the correction, including monitoring accuracy of processing, and correction of any problems.

A.4.1.4.22 Assure all daily, weekly, monthly, quarterly, annual and on request cycles are run correctly and on time.

A.4.1.4.23 Perform work as instructed in official transmittals. This may include extracting data from archived files.

A.4.1.4.24 Perform research immediately upon recognizing potential system problems in order to minimize system or payment impact and improve processing.

A.4.1.4.25 Submit reports of system errors and failures within one (1) business day of the occurrence.

A.4.1.4.26 Proactively maintain and upgrade all hardware and software to support Contract uptime and response time.

A.4.1.4.27 Assure that all licensed products for the systems, including, but not limited to, the OS, databases, and communications; are upgraded to the current, stable version. These products shall not be allowed to lapse into an unsupported version.

A.4.1.5 Maintenance Task Bureau Responsibilities:

A.4.1.5.1 Participate in weekly status meetings with the Contractor-designated system maintenance staff to monitor current operations and to monitor progress of maintenance activities.

A.4.1.5.2 Notify the Contractor in writing of system deficiency, as appropriate.

A.4.1.5.3 Receive and review notices of maintenance support or proposed Work Requests and System Change Requests from Contractor.

A.4.1.5.4 Review and approve Corrective Action Plans.

A.4.1.5.5 Work with the Contractor to determine priority of work requests.

A.4.1.5.6 Assist the Contractor in conducting a detailed requirements analysis on any major changes as required.

A.4.1.5.7 Monitor Contractor work request activities.

A.4.1.5.8 Assist in development of the test plan and in defining test conditions.

A.4.1.5.9 Review system test plan and approve test results.

A.4.1.5.10 Review monthly maintenance reports and summary log.

A.4.1.5.11 Review status meeting notes.

A.4.1.5.12 Review and approve required test results.

A.4.1.5.13 Review and approve updates to system documentation.

A.4.1.5.14 Submit transmittals with instructions on what needs to be done and by when.

A.4.1.5.15 Work with other contractors and other Bureau business partners to clarify data needs and approve any data extract work.

A.4.1.5.16 Monitor the Contractor's systems work and systems performance for accuracy and timeliness.

A.4.2 Operations Phase Modification Tasks

The Contractor shall be responsible for modifying, making changes and updating the TCMIS throughout the term of this Contract. This section of the Scope of Services describes how future changes or improvements to the system shall be categorized, the minimum staffing requirements, modification requirements that shall be accomplished, and how Bureau and Contractor responsibilities are defined.

To meet requirements, the associated TCMIS functions shall be updated and modified by the Contractor according to federal certification requirements, the CMS State Medicaid Manual, all federal mandates, and all State requirements, statutes, and regulations.

A.4.2.1 Modification Overview

Modifications, changes and updates are made to the TCMIS through a process of System Change Requests (SCRs). As of the Contract Start date, there is an existing workload of (SCRs) that shall continue to be addressed under this Contract term. The Contractor shall be responsible for managing, tracking and completion of the SCRs. The Contractor shall perform software modifications for all component parts of the TCMIS after the takeover, as requested by the Bureau. Some major program initiatives may require a prior-approved Advance Planning Document (APD) when additional resources are required. The Bureau shall be responsible for the production of all APDs.

A system modification exists when program source code shall be changed to implement a revised or new system functionality or performance requirement.

Software modifications may result when the Bureau or the Contractor determines that an additional requirement needs to be met or that a modification to existing file structures or current processing is needed.

A.4.2.1.1 The Contractor shall be responsible for modifying the TCMIS throughout the term of the Contract. All modifications or enhancements shall be made using a standard Systems Development Life Cycle (SDLC), as approved by the Bureau. The Bureau refers to changes or modifications to the system as "enhancements", not to be confused with the Enhancements outlined previously in this Contract. Examples of a modification include the following:

a) Changed functionalities not included in the existing TCMIS as specified in this Contract or not included in an Enhancement;

b) Implementation of new edits and audits or changes to existing edits or audits;

c) A change to established reports, screens, files formats, new data elements, or report items;

d) Activities necessary to meet new or revised Bureau or Federal requirements.

e) Activities necessary to meet Modification of Functionalities Bureau requirements.

A.4.2.1.2 The Contractor shall also enhance the software and component parts of the TCMIS (such as the TCMIS files and Web applications) as directed by the Bureau. Software enhancements may result when the Bureau or the Contractor determines that an additional requirement needs to be met which results in a change to existing file structures, data sets, or current processing logic.

A.4.2.1.3 The Contractor shall coordinate with the Bureau to use TeamTrack. TeamTrack shall track all System Change Requests (SCRs) with information on stage of development, priority, staff assigned, and dates associated with each stage of development.

A.4.2.1.4 The Contractor shall also be responsible for reporting monthly to Bureau managers and directors all systems changes that have been implemented in the month. This monthly report shall also include a three (3) month projection of the SCRs that shall be implemented in each month. Major projects, requiring more than three (3) months to complete, shall also be noted, with a status update on project milestones. For example, changes required by MITA may not be due for a year, but each monthly report shall include progress toward that due date by reporting on each project milestone's status.

A.4.2.2 System Modification Staffing Contractor Requirements:

The Contractor shall provide sufficient staff to perform all systems modification responsibilities as included in A.6.3 Maintenance and Modifications. These staff members may be located at the Bureau's site or off site, in accordance with the staff requirements listed in this Contract. The Contractor shall provide monthly reports to the Bureau detailing the activities by task for each of the staff performing modifications. The report shall include a summary of hours worked by staff by modifications task.

A.4.2.3 Modification Task Activities

Modifications may be initiated by the Bureau or the Contractor through submission of an SCR form. All change requests shall be prioritized and approved (or denied or modified) by the Bureau. The various types of modification support shall include:

A.4.2.3.1 The System Development Life Cycle, stages for this are:

A.4.2.3.1.1 Define requirements

A.4.2.3.1.2 Design Approaches

A.4.2.3.1.3 Develop Technical Specifications for the selected design

A.4.2.3.1.4 Develop a Test Plan

A.4.2.3.1.5 Perform Documentation Creation or Updates

A.4.2.3.1.6 Code and Unit Test

A.4.2.3.1.7 Perform Systems Integration Testing

A.4.2.3.1.8 Perform acceptance Test, including regression testing

A.4.2.3.1.9 Obtain approval of Acceptance Test

A.4.2.3.1.10 Perform Beta Testing (not required for all changes)

A.4.2.3.1.11 Migrate to Production environment

A.4.2.3.1.12 Perform verification of successful implementation

A.4.2.3.2 The Contractor shall post in TeamTrack for Bureau review an estimate of system modification efforts and schedule within five (5) business days of receipt, unless specified in the SCR (that may reduce that time frame) or for large project planning (that may increase that time frame). The response shall consist of a preliminary, high-level, non-binding assessment of the effort (number of total programmer and business analyst hours) required to complete the change. The purpose of the preliminary estimate is to quickly assess whether the value of the request exceeds the cost of performing the request. As requirements are further defined and a solution is designed, the preliminary estimate will be updated with a revised estimate.

A.4.2.3.3 Special Projects shall require additional staff and shall run in parallel so as to not impact modification work.

A.4.2.3.4 The Bureau may or may not choose to pursue certain modification requests. For those the Bureau chooses to pursue, the Contractor shall prepare a formal design estimate. This estimate shall define the problem to be addressed, propose a solution, and specify an estimated level of effort (number of hours) and anticipated schedule required to design, code, test, and implement the change, then approve or revise the request, assign a priority to it, and establish an expected completion date.

A.4.2.4 <u>Modification Processes</u>

A.4.2.4.1 Bureau approval shall be required on all modification task change requests to be complete. A change request shall be deemed successfully completed when:

A.4.2.4.1.1 It has been cancelled by the Bureau in writing; or

A.4.2.4.1.2 The Contractor has received a signoff in TeamTrack by an authorized Bureau representative(s); or

A.4.2.4.1.3 The modification has been successfully UAT tested and approved by the Bureau or the authorized representative for release to production, and has run successfully in production for thirty (30) calendar days or through a complete production cycle; and

A.4.2.4.1.4 All documentation has been drafted, approved by the Bureau, and posted to the appropriate documentation repository and approved by the Bureau.

A.4.2.5 Modification Task Contractor Requirements:

A.4.2.5.1 Use TeamTrack for tracking SCRs.

A.4.2.5.2 Receive system change requests (SCRs) from the Bureau.

A.4.2.5.3 Submit a system change request for Contractor-proposed changes.

A.4.2.5.4 Provide consultation to the Bureau in the development of modification requests.

A.4.2.5.5 Submit for approval to the Bureau, the planned Systems Development Life Cycle structure and all templates for engineering documents to be used.

A.4.2.5.6 Conduct detailed requirements analysis for changes, including recommendations, if any, for alternate approaches to meet the Bureau's needs.

A.4.2.5.7 Develop and submit requirements analysis and specifications to the Bureau for approval.

A.4.2.5.8 Once the request has been prioritized for action by the Bureau, prepare a reasonable estimate of staff effort and schedule, including impact on other projects and priorities as part of the release planning communications.

A.4.2.5.9 For all changes including those covered by an approved APD, develop detailed design documentation, including inputs, outputs, flow charts, file/database changes, program narrative and logic, program flow charts, and test plan.

A.4.2.5.10 For new functionality, develop updated user and system documentation wherever applicable.

A.4.2.5.11 Prepare and submit updated systems documentation as well as operational and user documentation if affected by the change.

A.4.2.5.12 Prepare and submit a test plan for approval.

A.4.2.5.13 Code programs/modifications.

A.4.2.5.14 Perform systems/unit tests.

A.4.2.5.15 Perform regression testing to confirm that modifications do not have unintended impacts to other existing processes.

A.4.2.5.16 Perform acceptance testing.

A.4.2.5.17 Submit unit, systems, regression and acceptance test results for review and approval.

A.4.2.5.18 Implement modifications following Bureau approval.

A.4.2.5.19 Verify the successful implementation of the modification, including monitoring the accuracy of processing and correction of any problems.

A.4.2.5.20 Ensure the integrity of data from prior periods.

A.4.2.5.21 Meet with the Bureau periodically on the status of all active systems enhancement modifications.

A.4.2.5.22 Organize and provide status and associated information during all status meetings that shall include a presentation by the Contractor Systems Manager on system modification activities. The periodic meeting shall allow the Contractor to report progress against schedules and any necessary schedule revisions, and shall allow for discussion of specific details where necessary. The Contractor shall document these meetings as minutes.

A.4.2.5.23 All completed work requests shall be retained for documentation and analytical purposes.

A.4.2.5.24 Provide monthly modification staffing hours reports that identify each individual performing modification tasks, by number of hours worked on modifications and hourly rate for each position performing modifications, if applicable.

A.4.2.5.25 Document all status meetings in minutes and provide minutes to the Bureau within two (2) business days after the meeting.

A.4.2.5.26 Utilize TeamTrack for tracking and reporting modification projects, and provide regular reports to the Bureau.

A.4.2.5.27 Perform work assignments according to priorities agreed to by the Bureau.

A.4.2.5.28 Conduct detailed requirements analysis for major changes.

A.4.2.5.29 Prepare, and submit for Bureau approval, an estimate of staff effort and schedule, including impact on other projects and priorities.

A.4.2.5.30 For minor changes, prepare a description of the required modifications.

A.4.2.5.31 For major changes, develop detailed design documentation, including inputs, outputs, flowcharts, file/database changes, program narrative and logic, program flowcharts, test plan, and user documentation, when required by the Bureau.

A.4.2.5.32 Perform unit testing on modifications.

A.4.2.5.33 Perform systems testing on modifications in coordination with Bureau staff.

A.4.2.5.34 Perform integration/regression testing on modifications in coordination with Bureau staff.

A.4.2.5.35 Submit test results to Bureau, if applicable.

A.4.2.5.36 Submit updates to systems documentation.

A.4.2.5.37 Implement modifications upon Bureau approval.

A.4.2.5.38 Verify the successful implementation of the modification, including monitoring accuracy of processing, and correction of any problems.

A.4.2.5.39 Prepare, submit, and distribute updates to TCMIS system documentation, user manuals, other user documentation, and any other necessary documentation within ten (10) business days of the date the change goes into production.

A.4.2.5.40 If the Contractor and the Bureau agree that the change request cannot be accomplished with the available staff, the Contractor shall respond with a detailed proposal, within fifteen (15) business days, containing:

A.4.2.5.40.1 A statement of the scope of the change request in relation to subsystems, functions, features, and capabilities to be changed;

A.4.2.5.40.2 Justification as to why the request cannot be accomplished with the available staff;

A.4.2.5.40.3 A breakdown of the work effort by milestone;

A.4.2.5.40.4 A breakdown of the work effort within each job category required;

A.4.2.5.40.5 A preliminary implementation schedule for the change request; and

A.4.2.5.40.6 A calculation of the estimated cost, based on the Special Projects rates in C.3.

A.4.2.6 <u>Modification Task Bureau Responsibilities:</u>

A.4.2.6.1 Participate in periodic status meetings.

A.4.2.6.2 Monitor current operations and progress on maintenance and modification activities.

A.4.2.6.3 Prepare and submit to the Contractor a written change request when a modification is required.

A.4.2.6.4 Receive and review notices of proposed change requests from Contractor.

A.4.2.6.5 Determine priority for Contractor completion of change requests, and return approved requests with priority assigned.

A.4.2.6.6 Be available to the Contractor for consultation in the development of a detailed requirements analysis on changes.

A.4.2.6.7 Assist the Contractor in conducting a detailed requirements analysis on any major changes as required.

A.4.2.6.8 Review and approve the general design and the detailed design for changes,

when required.

A.4.2.6.9 Monitor Contractor change request activities.

A.4.2.6.10 Review monthly modification reports and summary log.

A.4.2.6.11 Review status meeting minutes.

A.4.2.6.12 Review and approve required test plans, including testing responsibilities.

A.4.2.6.13 Assist in development of the test plan and in defining test conditions.

A.4.2.6.14 Review and approve required test results.

A.4.2.6.15 Review and approve updates to system documentation.

A.4.2.6.16 Review and approve updates to user and provider manuals and operations procedures (if required).

A.4.2.6.17 Approve implementation of modification.

A.4.2.6.18 Provide signoff once modification is approved.

A.4.2.7 Use of TeamTrack System

In order to assist Bureau staff in establishing reasonable completion dates and setting priorities for modifications, the Contractor shall use the TeamTrack System currently in use by the Bureau. This system allows Bureau and Contractor management staff to review current priorities and timeliness, change priorities by adding new tasks and target dates, and then immediately see the impact of these new priorities on pre-existing priorities and their target dates.

The objective of this system is to provide Bureau management with a means of incorporating new projects into pre-existing priorities and target dates, to see the overall impact on ongoing projects and their dates, and to provide a practical method to manage priorities.

A.4.2.8 TeamTrack System Requirements:

Information to be captured on the TeamTrack tracking system shall include, at a minimum, the following:

A.4.2.8.1 A unique number assigned by the Contractor to each approved system change;

A.4.2.8.2 Priority number to assigned priority of the project;

A.4.2.8.3 Functional area identifier;

A.4.2.8.4 Subsystems affected indicator - a yes/no indicator for each subsystem and or system component or functional area affected by the project;

A.4.2.8.5 Project description - a brief narrative description to help identify the project;

A.4.2.8.6 Request date - the date of the initial written request;

A.4.2.8.7 Requester - the name of the individual or unit initiating the change request;

A.4.2.8.8 Project start date - the date that work began on the project;

A.4.2.8.9 Assigned resource - the name of the primary resource person assigned to the project;

A.4.2.8.10 Estimated completion date - the target or the required project implementation date;

A.4.2.8.11 Estimated hours - the total hours estimated to complete the project or modification;

A.4.2.8.12 Hours worked to date - the total hours worked to date, by resource, by project;

A.4.2.8.13 Date documentation updates completed;

A.4.2.8.14 Expected completion date;

A.4.2.8.15 Project status - an indication of current project status, for example, on hold, delayed, in progress, in test, completed;

A.4.2.8.16 Change in project scope/project requirements; and

A.4.2.8.17 Project completion/implementation date - the date that the project requester or other delegated authority approves satisfactory completion of the project.

A.4.3 Special Project Support

There will be new projects that do not fall into normal change requests categories. These are typically large projects where the level of effort is significant and the duration is extended. These projects will not go through the normal change process and will be staffed and managed through dedicated resources, using the billable rates defined in the Contract.

Once a project is designated as special, the Contractor shall coordinate with the Bureau to perform an estimate and procure the additional funding approval.

A.4.3.1 Special Project Criteria

The criteria for a special project are as follows:

A.4.3.1.1 The requirements of the project are such that they cannot be performed using the existing staff or skill sets; or

A.4.3.1.2 The duration of the project is extended. The expected duration of the project is to extend beyond six (6) months; or

A.4.3.1.3 The number of resources is expected to be considerable. The expected staffing

for a change is more than five (5) dedicated resources; and

A.4.3.1.4 The project is of such complexity that a dedicated Project Manager is required.

Special Projects Staffing compensation shall be based on the Payment Rates detailed in this Contract for units of service authorized by the Bureau. The Bureau shall compensate the Contractor for Project work based on the hourly rates detailed in this Contract. The Contractor shall submit monthly invoices, in form and substance agreed to with the Bureau, with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall, at a minimum, include the name of each individual, the individual's job title, the number of hours worked during the period, the applicable payment rate, the total compensation requested for the individual, and the total amount due the Contractor for the period invoiced.

A.4.3.2 Special Projects Contractor Requirements

Several forthcoming State and federally mandated initiatives shall require changes to the TCMIS and business processes. The Contractor shall be aware of upcoming initiatives and be prepared to address the future needs.

A.4.3.2.1 The Contractor shall assess, implement, and/or operate/support all of the current and future initiatives listed in this Contract, as required by the Bureau.

A.4.3.2.2 The Contractor shall identify possible future requirements associated with these initiatives.

A.4.3.2.3 The Contractor shall identify possible future initiatives not already identified in the Contract that shall have an affect on the Bureau operations. The Contractor shall notify and submit a preliminary analysis to the Bureau pertaining to the initiative at least one (1) year prior to the mandated implementation date of the initiative.

A.4.4 Application Development and Testing Contractor Requirements

The Bureau requires isolated test environments designed to ensure computer applications are developed as specified. Separate test regions (e.g., unit, system, integration, and user acceptance) along with test data and appropriate copies of the logic modules that make up the system shall be established and maintained during Operations. Version control procedures and update schedules shall be used to facilitate tests, track discrepancies and facilitate regression test analysis. The Contractor shall provide the Bureau with isolated test environments, described below, to conduct independent integrated testing.

A.4.4.1 Application Development Testing Environments

Provide separate development and testing environments that:

A.4.4.1.1 Mirror all programs in production including reports and financial records;

A.4.4.1.2 Include a complete online TCMIS test system, including a test version of all batch and online programs and files to be used for testing releases and non-release changes;

A.4.4.1.3 Provide a library of test cases that may be selected and modified by the user for testing. Library shall have search capability that is cross referenced to the logic/edit that test case is designed to test;

A.4.4.1.4 Execute impact analysis testing of any proposed change when required;

A.4.4.1.5 Maintain regression test cases to support regression testing;

A.4.4.1.6 Save and reuse test cases without the need to re-enter the data;

A.4.4.1.7 Test cases shall be available to all appropriate Contractor and Bureau-designated staff;

A.4.4.1.8 Test all change requests before implementation; and

A.4.4.1.9 Allow users to create and edit any data as needed for testing.

A.4.4.2 Facilitate Testing

A.4.4.2.1 The Contractor shall create and execute a Bureau-approved test plan for each major change request before the change request is implemented, or as requested by the Bureau.

A.4.4.2.2 Conduct repeatable testing in accordance with written processes and procedures approved by the Bureau. The processes and procedures shall not be changed without prior approval by the Bureau. Test plans shall be created for major system changes or as otherwise requested by the Bureau and should include the following steps:

A.4.4.2.2.1 Conduct Unit Testing: Unit testing verifies the functioning of each portion of a product or segment of code separately.

A.4.4.2.2.2 Conduct Structured Data Tests: Structured data tests involve testing specific test cases with expected test results, then ensuring that those results are achieved.

A.4.4.2.2.3 Volume Testing consists of the following:

a) Conduct Load Testing: Load testing verifies that the system is able to handle the maximum number of users as documented in the system specifications;

b) Conduct Stress Testing: Stress testing verifies that the system will function within the allocated resources (e.g., disk space, processor size); and

c) Conduct Performance Testing: Performance testing verifies that the system performance meets the State's criteria in terms of online response times and completion of batch or cycle jobs in the window of time allocated.

A.4.4.2.2.4 Perform Operations Readiness Testing

A.4.4.2.2.5 Perform Parallel Testing

A.4.4.2.2.6 Conduct Integration Testing: Integration testing verifies that the interaction of that unit of code with other parts of the system should be tested.

A.4.4.2.2.7 Conduct System Testing: System testing verifies the following:

a) the proper functioning of all interfaces;

b) the proper processing of upstream feeds; and

c) the proper generation of downstream feeds.

A.4.4.2.2.8 Conduct Regression Testing: Regression testing verifies that the defect has been corrected, and that no new defect has been introduced.

A.4.4.2.2.9 Conduct User Acceptance Testing: Acceptance testing verifies that the system as a whole meets business requirements. Business users perform business functions in a testing environment using production-like data to ensure the system meets all business requirements.

A.4.4.2.2.10 Perform Retesting: All tests that fail and/or are defected shall be run again after the source of the failure is corrected.

A.4.4.2.3 Develop documentation of test results on all system changes shall be given to the Bureau for review and approval.

A.4.4.2.4 Implementation shall only begin after approval from the Bureau.

A.5 General Facilities Management Contractor Requirements

A.5.1 Data Center Operations

The State of Tennessee's Data Center is operated by the Office for Information Resources (OIR) within the Department of Finance and Administration. The State Data Center's mission is to provide technical resources and service to support a reliable, secure network and data infrastructure that enables government agencies to communicate, connect and compute. The TCMIS Data Center operates within this structure and is made up of two (2) general areas:

TCMIS portion of the State Data Center

TCMIS data acceptance, maintenance, retention and handling.

A.5.1.1 <u>TCMIS Data Center Contractor Requirements:</u>

A.5.1.1.1 Operate under OIR State Data Center guidelines.

A.5.1.1.2 Maintain Bureau LAN connectivity and provide technical support throughout the State to internal and external users of the TCMIS.

A.5.1.1.3 Provide system security to safeguard access to data and ensure integrity, completeness, and accuracy of data. Provide logons and levels of security for system users, and in accordance with HIPAA Security and Confidentiality requirements.

A.5.1.1.4 Operate and maintain a quality control program for system operations.

A.5.1.1.5 Schedule and run TCMIS processes and jobs as approved by the OIR and the Bureau.

A.5.1.1.6 Maintain a Disaster Recovery Plan and Business Continuity and Contingency Plan for the TCMIS and perform disaster recovery testing upon request from the State.

A.5.1.2 TCMIS Data Contractor Requirements:

A.5.1.2.1 Provide and maintain a comprehensive data retention plan for all system components and data in compliance with State and federal requirements.

A.5.1.2.2 Provide access to all data used in processing activities, including, but not limited to:

A.5.1.2.2.1 Enrollee Eligibility

A.5.1.2.2.2 Capitation payment

A.5.1.2.2.3 Claims payment

A.5.1.2.2.4 Encounter processing

A.5.1.2.2.5 Premium data

A.5.1.2.2.6 MCC Enrollee data

A.5.1.2.2.7 Provider enrollment

A.5.1.2.2.8 Benefits

A.5.1.2.2.9 Utilization

A.5.1.2.2.10 Reference data

A.5.1.2.2.11 Financial data

A.5.1.2.2.12 EPSDT

A.5.1.2.2.13 Medicare Buy-in

A.5.1.2.2.14 Premium data

A.5.1.2.2.15 Drug Rebate

A.5.1.2.2.16 Data resulting from exchanges with CMS and other organizations

A.5.1.2.2.17 TPL data

A.5.1.2.3 Accept TennCare information in standard formats and/or as defined by the Bureau.

A.5.1.2.4 Handle changes to data as defined by the Bureau.

A.5.1.2.5 Maintain online access to all systems and data as defined by the Bureau.

A.5.1.2.6 Store all TCMIS data and records for the period of time defined by the Bureau.

A.5.1.2.7 Archive all TCMIS data as defined by the Bureau.

A.5.1.2.8 Purge and archive data to permanent storage media according to requirements defined by the Bureau.

A.5.2 MMIS Certification

A.5.2.1 Certification Requirements Overview

The TCMIS shall meet federal certification requirements defined in the most current version of Part 11 of the State Medicaid Manual. The Contractor shall ensure that Enhancements of the TCMIS result in a complete, stable, and fully operational TCMIS. Federal certification may be requested retroactively to the start of full Contractor and system operations.

The Bureau is responsible for demonstrating to the federal review team how certification criteria are met and that the TCMIS is functioning in complete compliance with these regulations. The systems documentation finalized by the Contractor as part of the Enhancements shall be used to support the certification process.

Section 1903(a) of Title XIX provides ninety percent (90%) Federal Financial Participation (FFP) for development and seventy-five percent (75%) for operation of mechanized claims payment and information retrieval systems approved by CMS. In order for the State to receive the ninety percent (90%) FFP for development and implementation of enhancements to the TCMIS, and to receive the seventy-five percent (75%) for ongoing operations, the TCMIS shall meet and maintain all certification requirements. The Contractor shall ensure the TCMIS certification is continuous throughout the Enhancement period, and maintained throughout the term of this contract, and any amendments to extend this contract term.

The Contractor shall provide continuing post-operations support to the TCMIS through completion of Certification. The Contractor shall provide continuity in staffing from the Takeover through completion of Certification activities. The Contractor shall be required to retain sufficient Operations staff on-site to assist with resolving any problems or issues encountered during the initial months of operations. The Contractor shall communicate with the Bureau on a regular basis (e.g., daily) to discuss system performance and operational issues. The Contractor's Operations staff shall monitor the performance of the TCMIS and modify the TCMIS, as needed, to resolve problems identified during the initial months of operations.

In addition, if decertification of the TCMIS, or any component part of it, occurs prior to termination of the Contract, or any subsequent extension thereof, the Contractor shall be liable for resulting damages to the State.

A.5.2.2 MMIS Certification Contractor Requirements:

Contractor requirements shall include, but not be limited to:

A.5.2.2.1 Support the Bureau, as necessary, to identify CMS expectations related to a potential certification review

A.5.2.2.2 Submit and obtain approval of the final TCMIS systems documentation and

TCMIS operational documentation.

A.5.2.2.3 Complete and install updated versions of all system material previously submitted or missing in the online library.

A.5.2.2.4 Participate in certification planning, and prepare review materials to demonstrate system compliance with certification criteria.

A.5.2.2.5 Assist the Bureau in developing presentation materials.

A.5.2.2.6 Provide copies of all system outputs needed to demonstrate full functionality back to the start of Contract operations or the re-certification review period, whichever is later.

A.5.2.2.7 Participate, as necessary, during the federal on-site certification review.

A.5.2.2.8 Assist the Bureau in locating material needed to answer review team questions.

A.5.2.2.9 Provide any additional materials needed to resolve any post-review corrective actions.

A.5.2.2.10 Retain sufficient operations staff to provide post-implementation support during the initial months of operations through certification.

A.5.2.2.11 Monitor the performance of the TCMIS during the initial months of operations.

A.5.2.2.12 Modify the TCMIS, as needed, to resolve problems identified during the initial months of operations.

A.5.2.2.13 Resolve any and all corrective actions needed to finalize federal approval, with Bureau approval.

A.5.2.2.14 Meet with the Bureau on a regular basis to discuss post-implementation issues.

A.5.2.2.15 Propose solutions to post-implementation issues to the Bureau.

A.5.2.3 <u>MMIS Certification Bureau Responsibilities:</u>

A.5.2.3.1 Review and approve, or require correction of, the final TCMIS systems documentation.

A.5.2.3.2 Approve Contractor installation of all updated or previously missing items into the online systems library.

A.5.2.3.3 Assist in certification planning and review of Contractor materials prepared for the certification review.

A.5.2.3.4 Obtain information from Contractor staff as needed to prepare verbal presentations on system features and capabilities for the on-site review.

A.5.2.3.5 Obtain information from the Contractor to facilitate the submission of any corrective action materials needed to finalize federal approval.

A.5.2.3.6 Meet with the Contractor on a regular basis to discuss post-enhancement implementation issues through certification.

A.5.2.4 Contractor Certification Deliverables:

Completion and payment for Certification shall be based upon Bureau approval of the following deliverables:

A.5.2.4.1 Bureau approval of TCMIS systems documentation.

A.5.2.4.2 Completion of the online source code library with updated versions of all previous materials and new material previously missing.

A.5.2.4.3 Review final certification documents.

A.5.2.4.4 Federal certification of the TCMIS.

A.5.2.4.5 Contractor demonstrations that TCMIS financial data and claims inventory counts are being verified through routine balancing procedures.

A.5.2.4.6 Contractor demonstrations that all TCMIS claim types are being processed at production volumes and within timeliness of claims processing requirements, as defined in Section B.3.3.4 of Attachment B of this Contract which includes the commitments for Claims processes.

A.5.2.4.7 Contractor demonstrations that system reports are being delivered to Bureau users according to the performance requirements, as defined in Section B.3.3.26 of Attachment B of this Contract.

A.5.3 Software License Maintenance

The Contractor shall describe in detail any planned software applications intended for use in the TCMIS, and make apparent any proposed deviations from current processes and software. Whether new COTS applications are planned, or existing software packages are proposed. The Contractor shall obtain and maintain the software licensure and any additional copies required as directed by the Bureau, in accordance with Section C.3(f) Hardware, Software and Maintenance.

A.5.4 Business Continuity and Contingency Plan – Disaster Recovery, System Back-up

A.5.4.1 Business Continuity and Contingency Plan

The Contractor shall deliver a preliminary Business Continuity and Contingency Plan (BCCP) during the Start-up and Implementation activities, and shall update and test this plan as agreed upon with the Bureau. The plan shall be in accordance with state standards as established by the Tennessee Emergency Management Agency (TEMA) for Continuity of Operations Plan documentation. The BCCP plan shall establish adequate backup processes for all TCMIS

systems and operational functions and address the potential impacts of disaster occurrence. The contingency plans shall be composed of two (2) fundamental operations - System Back-up and Disaster Recovery. The Contractor shall use State equipment, facilities, network, print center and data center for TCMIS operations. Therefore, the Contractor shall rely on the State's Continuity Plan in regard to these items.

A.5.4.2 System Back-up and Disaster Recovery Contractor Requirements:

A.5.4.2.1 The Contractor shall establish and maintain daily back-ups that are adequate and secure for all computer software and operating programs, databases, files, and systems, operations, and user documentation (in electronic and non-electronic form) that are updated on a daily basis.

A.5.4.2.2 The Contractor shall establish and maintain a weekly back-up that is adequate and secure for all computer software and operating programs, databases, files, and systems, operations, and user documentation (in electronic and non electronic form).

A.5.4.2.3 The Contractor shall develop a plan for physical and system security that shall identify all potential security hazards at the physical site, including systems and networks, and shall identify the associated protection plans for the TCMIS assets and controls.

A.5.4.2.4 The Contractor shall follow all applicable technical standards for site and system security during the operation of the TCMIS, using best practices as developed by the National Institute of Standards and Technology (NIST).

A.5.4.2.5 The Contractor shall provide for off-site storage of back-up operating instructions, procedures, reference files, systems documentation, programs, procedures, and operational files. Procedures shall be specified for updating off-site materials.

A.5.4.2.6 The Contractor shall establish and maintain complete daily back-ups of all data and software and support the immediate restoration and recovery of lost or corrupted data or software.

A.5.4.2.7 Disaster planning documentation and procedures shall be approved by the Bureau and put in place before system operations begin.

A.5.4.2.8 The Contractor, in conjunction with the Bureau, shall provide for a back-up processing capability at a remote site(s) from the Contractor's primary site, such that normal payment processing, as well as other system and Bureau services deemed necessary by the Bureau, can continue in the event of a disaster or major hardware problem at the primary site(s).

A.5.4.2.9 The Contractor shall coordinate planning for off-site procedures, locations, and protocols through the Bureau in advance.

A.5.4.2.10 The Contractor shall clearly document all of the components and file systems that would be required for a full restore.

A.5.4.2.11 The Contractor shall document batch processes as to sender, receiver, location, process, date and databases updated and have a plan that details how each batch process would be supported and carried out to achieve a full restore.

A.5.4.2.12 In the event of a disaster, the Contractor shall specify the respective time frames deemed reasonably necessary for complete recovery.

A.5.4.2.13 The recovery period, in the event of a catastrophic disaster, shall not exceed thirty (30) calendar days.

A.5.4.2.14 The recovery period, in the event of a disaster caused by criminal acts or natural disasters, shall not exceed ten (10) calendar days.

A.5.4.2.15 The Contractor shall take all steps necessary to fully recover the data and/or system from the effects of a disaster and to reasonably minimize the recovery period.

A.5.4.2.16 The Contractor shall perform back-up demonstrations at no additional cost to the Bureau. Failure to successfully demonstrate the procedures may be considered grounds for termination of this Contract. The Bureau reserves the right to waive part or all of the demonstrations. In the event the Contractor's test is deemed by the Bureau to be unsuccessful, the Contractor shall continue to perform the test until satisfactory, at no additional cost.

A.5.4.2.17 The Contractor shall develop a Business Continuity and Contingency Plan that identifies the core business processes involved in the TCMIS.

A.5.4.2.18 The BCCP Plan shall be available and present at the Bureau site.

A.5.4.2.19 The BCCP shall identify potential system failures for each core business process.

A.5.4.2.20 The BCCP shall contain a risk analysis for each core business process.

A.5.4.2.21 The BCCP shall contain an impact analysis for each core business process.

A.5.4.2.22 The BCCP shall contain a definition of minimum acceptable levels of outputs for each core business process.

A.5.4.2.23 The BCCP shall contain documentation of contingency plans.

A.5.4.2.24 The BCCP shall contain definition of triggers for activating contingency plans.

A.5.4.2.25 The BCCP shall contain discussion of establishment of a business resumption team.

A.5.4.2.26 The BCCP shall address maintenance of updated disaster recovery plans and procedures.

A.5.4.2.27 The BCCP shall address planning for replacement of personnel to include:

A.5.4.2.27.1 Replacement in the event of loss of personnel before or after signing this Contract;

A.5.4.2.27.2 Replacement in the event of inability by personnel to meet performance standards;

A.5.4.2.27.3 Allocation of additional resources in the event of the Contractor's inability to meet performance standards;

A.5.4.2.27.4 Replacement/addition of personnel with specific qualifications;

A.5.4.2.27.5 Time frames necessary for replacement;

A.5.4.2.27.6 Contractor's capability of providing replacements/additions with comparable experience; and

A.5.4.2.27.7 Methods for ensuring timely productivity from replacements/additions.

A.5.4.2.28 The system shall maintain appropriate checkpoint/restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications for voice and data circuits, and disaster recovery.

A.5.4.2.29 The Contractor shall be required to prepare and maintain a Disaster Recovery Plan as part of the BCCP and provide the Bureau with up-to-date electronic copies at least once a year during the term of this Contract. The disaster recovery plan shall be submitted to the Bureau for approval prior to the systems implementation and whenever changes are required.

A.5.4.2.30 The Contractor shall ensure that each aspect of the Disaster Recovery Plan is detailed as to both Contractor and Bureau responsibilities and shall satisfy all requirements for federal certification. Normal TCMIS day-to-day activities and services shall be resumed within five (5) working days of the inoperable condition at the primary site(s).

A.5.4.2.31 The Contractor shall dedicate two (2) Subject Matter Experts (SMEs) to be onsite to participate in the disaster recovery drills.

A.5.4.2.32 The Contractor shall coordinate with OIR to test and certify near real-time failover utilizing replicated data and Veritas Clustering software.

A.5.4.2.33 The Disaster Recovery Plan shall address Checkpoint/restart capabilities.

A.5.4.2.34 The Disaster Recovery Plan shall address retention and storage of backup files and software.

A.5.4.2.35 The Disaster Recovery Plan shall address Hardware backup for the main processor(s).

A.5.4.2.36 The Disaster Recovery Plan shall address network backup for voice and data telecommunications circuits.

A.5.4.2.37 The Disaster Recovery Plan shall address Contractor provided voice and data

telecommunications equipment.

A.5.4.2.38 The Disaster Recovery Plan shall address the Uninterruptible Power Source (UPS) at both the primary and alternate sites with the capacity to support the system and its components.

A.5.4.2.39 The Disaster Recovery Plan shall address the continued processing of TennCare transactions (claims, eligibility, provider file, and other transaction types), assuming the loss of the Contractor's primary processing site. This shall include interim support for the Bureau online component of the TCMIS and how quickly recovery may be accomplished.

A.5.4.2.40 The Disaster Recovery Plan shall address back-up procedures and support to accommodate the loss of online communication between the Contractor's processing site and the Bureau.

A.5.4.2.41 The Disaster Recovery Plan shall contain detailed file back-up plan and procedures, including the off-site storage of crucial transaction and master files. The plan and procedures shall include a detailed frequency schedule for backing up critical files and (if appropriate to the back-up media) their rotation to an off-site storage facility. The off-site storage facility shall provide security of the data stored there, including protections against unauthorized access or disclosure of the information, fire, sabotage, and environmental considerations.

A.5.4.2.42 The Disaster Recovery Plan shall address the maintenance of current system documentation and source program libraries at an off-site location.

A.5.4.2.43 The Contractor shall provide documentation defining back-up processing capacity and availability. Included shall be a prioritized listing of all of the Contractor's back-up processing that shall be performed at the back-up processing facility in the event of an inoperable condition at the primary site. Estimated back-up processing capacity utilization shall be included for each back-up processing item listed. Documentation shall include written agreements with the management of the back-up processing facility. Agreements shall identify duties and responsibilities of all parties involved as well as specify the level of back-up service to be provided to the Bureau.

A.5.4.2.44 The Contractor shall demonstrate the disaster recovery capability for all critical system components at a remote site once during the first year of this Contract period and no less often than every two (2) calendar years, in accordance with the 45 CFR §95.621(f). The demonstration at the remote site shall be performed for all administrative, manual, input, processing, and output procedures functions, and include:

A.5.4.2.44.1 The processing of one (1) daily and one (1) weekly payment processing cycle, at a minimum;

A.5.4.2.44.2 A test of all online transactions;

A.5.4.2.44.3 A test of query and reporting capability; and

A.5.4.2.44.4Verification of the results against the corresponding procedures and production runs conducted at the primary site.

A.5.4.3 Business Continuity and Contingency Plan Deliverables:

A.5.4.3.1 Submit BCCP and Disaster Recovery Plans to the Bureau at least sixty (60) days prior to Modified Operations Start Date, and updated annually thereafter.

A.5.4.3.2 Submit a Security Plan within sixty (60) calendar days prior to the Modified Operations Start Date, and update annually thereafter.

A.5.4.4 BCCP Bureau Responsibilities:

A.5.4.4.1 The Bureau shall approve the Business Continuity and Contingency Plan.

A.5.4.4.2 The Bureau shall oversee and approve all back-up and recovery demonstrations.

A.5.5 Quality Assurance/Quality Improvement

The Contractor shall be committed to quality and shall continually plan for, promote, implement, and constantly improve quality in all Contractor activities. The Contractor shall develop a Quality Assurance/Quality Improvement (QA/QI) plan that shall reflect the Contractor's experience and resolve toward quality in systems design, testing, and implementation; process design and staff training; performance standards development and measurement; and customer satisfaction measurement and analysis. As part of its approach to quality management, the Contractor shall develop, support, measure and report progress against system metrics or software measurement criteria to allow both the Contractor and the Bureau to assess the progress of the Start-up, Modifications, Operations, and Enhancement processes. The quality measurement process applies to plans and documents, as well as programs and operational functions. The Quality Management plan shall reflect a process for sampling and audits and for continuous quality improvement. Areas in which to focus quality assurance efforts shall include, but not be limited to:

Eligibility and Enrollment activities;

Version control and change management;

System Documentation;

Testing activities;

Operational processing;

Claims processing and data entry; and

System Change Requests (SCRs) and WRs.

A.5.5.1 System Functionality Contractor Requirements:

A.5.5.1.1 The Contractor shall identify and inform the Bureau of any procedure or technology which may reduce the cost and/or increase the effectiveness of administering the TennCare program, including claims and encounter

processing, capitation payments, eligibility and enrollment processing, quality control, file maintenance, system operations, enrollee notification, and premium processing.

A.5.5.2 Business Process Functionality Contractor Requirements:

A.5.5.2.1 Prepare an annual aggregate report of findings and recommendations for quality improvements.

A.5.5.2.2 Design data analysis initiatives to support effective cost containment and quality improvement initiatives.

A.5.5.2.3 Monitor quality and work toward continued quality improvement, to include, but not limited to:

A.5.5.2.3.1 Provide information from reviewers independent of the staff performing the function;

A.5.5.2.3.2 Report on quality compared to previous periods;

A.5.5.2.3.3 Initiate, document and implement, at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months; and

A.5.5.2.3.4 Document and implement corrective action plans when requested by the Bureau.

A.5.5.2.4 Develop quality measurements.

A.5.5.2.5 Provide and execute quality assurance procedures to ensure that the financial management system disburses, tracks, and accounts for the Bureau of TennCare payments accurately.

A.5.5.2.6 Implement a quality assurance program to review claims processed through the system, to ensure claims resolution and claims adjudication activities are performed in accordance with approved guidelines.

A.5.5.2.7 Operate and maintain a quality control program for system operations, which shall ensure a mechanism that eliminates the potential for problems with version control when testing software and shall include procedures for deliverable standards, deliverable version control, and deliverable quality assurance reviews.

A.5.5.2.8 Develop and implement a Bureau approved Test Plan for all system modifications that will ensure testing thoroughness, documentation of results and tracking of changes or fixes still remaining, to include, but not limited to:

A.5.5.2.8.1 A test plan and schedule for each unit, module, and subsystem including any integrated system testing as required;

A.5.5.2.8.2 A description of all test situations and all expected test results;

A.5.5.2.8.3 A comparison process for the test results;

A.5.5.2.8.4 Tracking of all discrepancies;

A.5.5.2.8.5 Procedures for updating documentation impacted;

A.5.5.2.8.6 Quality Control review prior to presentation to the Bureau for review;

A.5.5.2.8.7 Process for corrective actions required; and

A.5.5.2.8.8 Migration procedures for implementation into production.

A.5.5.3 Contractor Quality Assurance Deliverables:

A.5.5.3.1 Quality Assurance/Quality Improvement (QA/QI) Plan.

A.5.5.3.2 SCR reduction plan.

A.5.5.3.3 Sample Test Plan.

A.5.6 General Contractor Requirements

A.5.6.1 Contractor Relationship with the Bureau of TennCare

The Contractor staff shall have an ongoing relationship with the Bureau's staff that is based on trust, confidentiality, objectivity, and integrity. As TCMIS operations specialists, the Contractor shall be privy to internal policy discussions, contractual issues, price negotiations, and confidential medical information, Bureau financial information, and advance knowledge of legislation.

As part of the tasks described in this section, the Contractor shall be responsible for the following general Contract requirements:

A.5.6.1.1 Work cooperatively with key Bureau staff and the staff of other contractors as required in the course of this Contract period.

A.5.6.1.2 Operate the Bureau's system at all times according to federal and State regulations.

A.5.6.1.3 Inform Bureau management staff on current trends and issues in the MMIS marketplace, and provide information on new technologies in use in other states.

A.5.6.1.4 Work cooperatively with Bureau staff assigned to the TCMIS project to ensure the success of the project.

A.5.6.1.5 Maintain complete and detailed records of all meetings, system development life cycle documents (also known as engineering documents), project meetings, presentations, start-up and enhancement planning issues, and any other interactions related to the TCMIS project described in this Contract and make such records available to the TCMIS Project Director and management on a regular basis, throughout the term of this Contract.

A.5.6.1.6 The Contractor shall be solely responsible for all of the work to be performed

under this Contract, regardless of whether subcontractors are used. The Bureau shall work solely with the prime Contractor to perform all Contract administration activities of this Contract, including tasks for which the subcontractor may be responsible. Nothing contained within this document or any Contract documents created as a result of any Contract awards derived from this Contract shall create any contractual relationships between any subcontractor and the Bureau.

A.5.6.1.6.1 All subcontracting relationships require the consent and approval of the Bureau prior to start of work under this Contract. The estimated percentage of total work effort shall also be included for each subcontractor, and subcontracted work shall not, collectively, exceed forty percent (40%) of the total Contract price.

A.5.6.1.6.2 At a minimum, the subcontractor information shall include: name, address, the general scope of work to be performed by each subcontractor, the subcontractor willingness to perform such work, and certification that the subcontractor does not discriminate in its employment practices. The Contractor shall report to the Bureau annually information on its use of subcontractors, certifying that the subcontractor meets the employment practices mandated by federal and State of Tennessee statutes and regulations.

A.5.6.2 Contractor Commitment To Quality Management

The Contractor shall perform an essential role in the Bureau administration. To maintain continuous focus on the importance of delivering quality systems and services, the Contractor shall plan, implement, rigorously endorse, and constantly improve a quality assurance program.

The Bureau does not seek a textbook approach to quality management. Instead, the Bureau seeks Contractor endorsement of the fundamental importance of quality imbedded in a living plan to introduce, promote, reinforce, and acknowledge quality in all Contractor activities.

A Quality Assurance/Quality Improvement (QA/QI) Plan shall have been developed as part of the Proposal and refined early to address the needs and specific opportunities for quality improvement throughout this Contract period.

A.5.6.2.1 The QA/QI plan shall reflect the Contractor's experience and resolve toward quality in systems design, testing, and implementation; process design and staff training; performance standards development and measurement; and customer satisfaction measurement and analysis.

A.5.6.2.2 As part of its approach to quality management, the Contractor shall develop, support, and report progress against system metrics or software measurement criteria to allow both the Contractor and the Bureau to assess the progress of the Start-up, Operations, and Enhancement Phases.

A.5.6.3 Functional Area Contractor Requirements:

A.5.6.3.1 Compliance with Federal Standards

The system shall meet all federal requirements for certification as prescribed in the State Medicaid Manual, Part 11, as well as Titles 42 and 45 of the CFR. In addition, the Contractor

shall assist the Bureau in systems and operational compliance efforts with ongoing legislation passed at the federal or State level.

A.5.6.3.1.1 Health Insurance Portability and Accountability Act (HIPAA)

The Contractor shall ensure it continuously meets all federal regulations regarding standards for privacy, security, electronic healthcare transactions, healthcare code sets and individually identifiable health information as identified in the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended. The Contractor shall also handle the transition of other future requirements of HIPAA, including the Health Information Technology for Economic and Clinical Health Act (HITECH), which may impact system and policy operations for the Bureau. The Contractor shall maintain and operate TCMIS in full compliance with HIPAA. The Contractor shall be responsible for HIPAA compliance of TCMIS and the Facilities Manager operations regardless of its status as a covered entity or business associate. The actual damages for the Contractor's failure to comply with the HIPAA standards shall be any penalties that the Bureau is assessed.

A.5.6.3.1.2 Medicaid Information Technology Architecture (MITA)

The federal government's Center for Medicaid and State Operations (CMSO) has launched an initiative, known as the Medicaid Information Technology Architecture (MITA), to establish federal/State partnerships promoting technologies and processes that support flexibility and adaptability, and can rapidly respond to changes in the Medicaid program. The Contractor shall support this MITA initiative. The goals of MITA include:

Reducing costs by integrating interoperable systems that can share data and achieve common medical assistance program goals;

"Modularity" through reusable system components, so that a single component can be upgraded or replaced without having to replace the entire "system";

Adopting and promoting industry standards;

Easy accessibility to timely and accurate data in order to make administrative and program decisions;

Enabling technologies to support medical assistance program business processes;

Performance management linking planning, measurement and accountability; and

Strategic coordination with healthcare partners to improve medical assistance program health outcomes.

The Bureau has made the decision to incorporate MITA principles into its system infrastructure as practicable, focusing on aligning technological needs with business needs.

A.5.6.3.1.3 Medicare Modernization Act (MMA)

The system shall support and coordinate with Medicare Modernization Act (MMA) and Medicare Part D plan implementation and operation.

A.5.6.3.2 Security, Confidentiality, and Auditing

The Contractor shall ensure that the TCMIS enhancements and operations are in accordance with both State and federal regulations and guidelines related to security, confidentiality, and auditing.

A.5.6.3.2.1 Security

The Contractor shall follow all applicable technical standards for site and system security during the operation of the TCMIS, using best practices as developed by the National Institute of Standards and Technology (NIST) and the State Security Policy and in particular its Application Security controls.

The Contractor shall develop a plan for the physical and system security for each of its facilities used in meeting the requirements of this Contract. This plan shall use the NIST Special Publication 800-18 (Guide for Developing Security Plans for Federal Systems). This plan shall be submitted initially to the Bureau within thirty (30) calendar days of the Contract Start date. The Contractor shall submit an updated plan annually no later than the anniversary date of the Contract Start date. This plan shall identify all potential security threats and hazards to the physical sites, systems and network, including the probability of occurrence, and shall identify the assets and controls to protect against such threats and hazards. The Contractor may submit this plan in conjunction with the business continuity and disaster recovery plan.

The Bureau shall approve, reject, or request modifications of the plan within fifteen (15) calendar days of receipt of the plan.

The Contractor shall apply all security patches for the operating system and any other software for the system within twenty-four (24) hours of release. This includes third-party software which shall be supported and remain current. In addition, all risk vulnerabilities identified shall be reported to the Bureau. Vulnerabilities shall be patched immediately upon approval of the Bureau. All workstations and Servers that access the systems shall also have antivirus software installed, and this software shall remain current. The Contractor shall configure and maintain a firewall to restrict access to systems from all unauthorized users. Access to the systems shall be controlled and restricted to only those with a need to access that system. Software used shall be continually supported by the software vendor. The Contractor shall be able to support the most current version of Windows OS within nine (9) months of official release, or as otherwise directed by the Bureau.

A.5.6.3.2.2 Confidentiality

The Contractor shall abide by all of the HIPAA Privacy Regulations found at 45 CFR Part 160 and Part 164 and including future revisions and additions to such regulations. This includes agreement to control the use or disclosure of Protected Health Information as permitted or required by this agreement or as required by law. The Contractor shall establish, maintain, and use appropriate safeguards to prevent use or disclosure of enrollee and provider personal information used by the Contractor. This information shall be held confidential and shall not be divulged without the written consent of the Bureau and the written consent of the enrolled enrollee, his or her attorney, and his or her responsible parent or guardian, except as may otherwise be required by the Bureau. Nothing shall prohibit the disclosure of information in summary, statistical, or

other form that does not identify particular individuals, consistent with the rules for non-identifiable information in the HIPAA Privacy law.

All documents, data compilations, reports, computer programs, photographs, and any other work provided to or produced by the Contractor in the performance of this Contract shall be kept confidential by the Contractor until publicly released by the Bureau or until written permission is granted by the Bureau for its release.

All Contractor employees assigned to the TennCare account or having access to TennCare data shall be instructed, in writing, of this requirement and shall be required to sign a document to this effect. Training for all employees shall be conducted annually, and new employees shall be trained within sixty (60) days of hire.

Publicly available information shall not be released by Contractor, unless specifically authorized by the Bureau. Prior to release of Protected Health Information (PHI) to any non-Bureau entity, Contractor shall verify with the Bureau that the requesting party has signed the Bureau's HIPAA Business Associate Addendum. Before disclosing any privileged information (e.g., attorney, enrollee information), the Contractor shall verify with the Bureau that such information may be disclosed.

A.5.6.3.2.3 Auditing

The Contractor shall ensure that the TCMIS facilitates auditing of individual transactions. Automated audit trails shall be provided throughout the system to identify and track results of transaction processing, changes to master file data (e.g., eligibility, provider, reference), and all edits encountered, resolved, or overridden. Contractor shall coordinate with Bureau Internal Audit and provide daily, weekly or other random samples as requested of TCMIS processing records in accordance with Attachment B.

Audits may be performed by a number of State and federal agencies, including, but not limited to, the Bureau or its designee, the Centers for Medicare and Medicaid Services and the Office of the Comptroller of the Treasury.

An independent auditor shall perform SAS-70 Type I audits at the Contractor's operations site annually, beginning after the end of each State Fiscal Year and submitted to the Bureau no later than four (4) months after the start of the subsequent State Fiscal Year, unless otherwise approved by the Bureau. Control objectives of the SAS-70 Audit will be specified and approved by TennCare. Findings and action plans shall be submitted to the Bureau. No additional funding shall be allocated to perform the audit tasks. Therefore, these audits should be included in the price of this Contract. The Contractor and all subcontractors shall provide reasonable access to all facilities and assistance to the Bureau and federal representatives. All inspections and evaluations shall be performed in such a manner as will not unduly delay work. The Contractor shall also provide support to the Bureau, including selection of samples, production of hard-copy documents, and

gathering of other required data. The Contractor's staff shall assist Bureau staff in responding to CMS inquiries. This level of support shall also be provided to all other State audit agencies or their designees.

An audit may include, but is not limited to, the following capabilities and applies to the current system:

1. Auditing claims after payment to determine that all regulations have been satisfied, the claim has been adjudicated and paid correctly, and any system or regulation changes have been properly made. Automated audit trails shall be provided throughout the system to identify and track results of transaction processing; changes to master file data (e.g., eligibility, provider, reference); and all edits encountered, resolved, or overridden. The system has, and shall maintain, the capability to revise affected files after completion of the audit.

2. Analyzing provider refunds and claim adjustments to determine the cause of erroneous expenditures.

3. Demonstrating services were provided for eligible enrollees.

4. Using computer audit programs to generate audit modules to perform random or spot quality control audits on all claims processing and related files.

5. Storing, retrieving, and executing programs online, whether such programs are generated by the audit staff, are part of the Contractor's production system, or are generated by Contractor staff.

6. Processing of test data to determine that the system is operating properly.

7. Tabulating claims rejected because of processing errors broken down by type of error and personnel involved.

8. Reviewing manually processed transactions (e.g., those claims that are paid by overriding edit checks or are manually priced).

9. Reviewing the Contractor's organization, policies, procedures and practices, effectiveness of controls, operating efficiency, facility and software security, and back-up procedures.

10. Reviewing the Contractor's compliance with Contract terms, system specifications, health law, State or federal regulations, administrative directives, and program documentation.

11. Reviewing any phase or aspect of the TCMIS for any purpose related to the system.

12. Verification of appropriate segregation of duties among staff with regard to TennCare's applications and adequate mitigating controls to minimize the risks associated with the initiation, perpetuation, and concealment of unauthorized and of fraudulent activities.

A.5.6.3.2.3.1. The Contractor shall provide secure access to files, documentation, and Contractor personnel. Auditors shall be given

access to all Contractor personnel and facilities. The Contractor shall provide read-and-copy access to all the files. Such files shall include, but are not limited to: the inventory control files, eligibility master file, formulary, diagnosis and procedure files, provider master files, all pricing files, intermediate files, and adjudicated claims file.

A.5.6.3.2.3.2. The Contractor shall provide secure access to computer files and documentation. Access to the following types of documentation includes, but is not limited to:

All software and operating manuals;

All documentation, including, but not limited to, rules, regulations, memos, internal reports, and detail design documentation as well as the facilities and the right to photocopy any and all documentation; and

All Contractor-supplied training materials.

A.5.6.3.2.3.3. The Contractor shall provide secure access to computer resources. Computer resources includes, but is not limited to:

All application programs and libraries;

All systems programs and libraries;

Operating system, including, but not limited to, job accounting/software; and

Computer time.

A.5.6.3.2.3.4. The Contractor shall provide the personnel and resources necessary for the automated and/or manual sampling of claims and reference file data, including, but not limited to, the retrieval of historical data.

A.5.6.3.2.3.5. Requirements for access to records are governed by 45 CFR Part 74. The Contractor, in accordance with this regulation, shall maintain accounting books, accounting records, documents, and other evidence pertaining to the administrative costs and expenses of this Contract to the extent and in such detail as shall properly reflect all revenues, all net costs, direct and apportioned, and other costs and expenses, of whatever nature, that relate to performance of contractual duties under the provisions of this Contract.

A.5.6.3.2.3.6. The Contractor's accounting procedures and practices shall conform to generally accepted accounting principles, and the costs properly applicable to this Contract shall be readily ascertainable.

A.5.6.4 Communications Contractor Requirements:

The Contractor shall maintain telephone and email contact with the TCMIS Project Director and other designated staff on a consistent basis throughout the Contract term. The Contractor shall provide management, supervisory and technical staff availability by email for ease of communication with the Bureau. The project coordinator and/or designated staff shall also participate in weekly status meetings in person or by telephone conference call and shall provide regular status reports on a schedule to be determined by the Bureau.

A.5.6.5 System Reliability and Performance Standards

The Contractor shall, at all times, comply with system and operational performance requirements and standards specified in this Contract including, but not limited to, the performance commitments as they refer to the TCMIS and its operations and the use of Facilities Manager services.

The performance commitments (refer to Attachment B) contain specific system and operational performance requirements the Contractor shall adhere to for the term of this Contract. Failure to comply with these requirements may result in liquidated damages. System and operational performance requirements are provided in this Contract for various functions, including, but not limited to, the following:

A.5.6.5.1 Business Hours of Operation

A.5.6.5.2 System availability and processing times

A.5.6.5.3 Report generation and availability

A.5.6.5.4 Deliverable turnaround timeframes

A.5.6.5.5 Error rates

A.5.6.5.6 Processing times

A.5.6.5.7 Report generation and availability

A.5.6.5.8 Quality of operations

A.5.6.5.9 Prevention of errors in payments

A.5.6.5.10 Help Desk Operations

A.5.6.5.11 Incident Resolution

A.5.6.5.12 Data and System Recovery

A.5.6.5.13 Database archival requirements

The Contractor shall also provide appropriate functions and protocols necessary to ensure system reliability and recovery, including, but not limited to, telecommunications and networking reliability, file backups, and disaster recovery.

A.5.6.6 Electronic Data Transmission and Translation Function

To meet the HIPAA requirements for transactions and code sets, the Contractor shall provide a HIPAA translation function for all transactions coming from the web, eligibility vendors, providers, and clearinghouses. The HIPAA-standardized electronic data transmission transactions interface with the TCMIS through a translator. The majority of the Bureau's transactions are conducted electronically, thus the electronic data transmission and translation function is a central

component of TCMIS functionality. It shall provide reliability and capacity for volume, peak loads, and quick processing speeds.

The Contractor's translation approach shall include the ability to receive and process all HIPAA transaction sets and the ability to store and utilize all data elements submitted on the following HIPAA transaction and other ANSI ASC X12N data sets:

A.5.6.6.1 Health Care Coverage, Eligibility, and Benefit Inquiry (270)

A.5.6.6.2 Health Care Coverage, Eligibility, and Benefit Response (271 and 271U)

A.5.6.6.3 Claims Attachments (275) – when mandated (not currently accepted)

A.5.6.6.4 Health Care Claims Status Request (276) (not currently accepted)

A.5.6.6.5 Health Care Claims Status Response (277) (not currently accepted)

A.5.6.6.6 Health Care Services Review – Request for Review and Response (278) (not currently accepted)

A.5.6.6.7 Health Care Services Review – Notification and Acknowledgement (Unsolicited 278) (not currently accepted)

A.5.6.6.8 Payroll Deducted and Other Group Premium Payment for Insurance Products (820)

A.5.6.6.9 Benefit Enrollment and Maintenance (834)

A.5.6.6.10 Health Care Claims Payment/Advice (835)

A.5.6.6.11 Health Care Claim: Institutional (837I)

A.5.6.6.12 Health Care Claim: Professional (837P)

A.5.6.6.13 Health Care Claim: Dental (837D)

A.5.6.6.14 NCPDP

A.5.6.6.15 Other electronic transactions defined in the interfaces section

A.5.6.7 Data Maintenance

The TCMIS shall continue to provide the flexibility for Bureau-authorized users to update data, in both an online and batch manner, due to changes in enrollment, processing of claims, changes in standard health care code definitions, changes in rate settings, or other regular events which are a part of the Bureau's ongoing business operations. Below are specific requirements related to existing functionality for data maintenance.

A.5.6.7.1 The system shall be able to add, change and/or delete any/all system maintained data through online or batch update.

A.5.6.7.2 The system shall use, to the greatest extent possible, online, real-time updates from the Bureau approved data processing devices.

A.5.6.7.3 The system shall provide the ability to perform mass updates on any/all system-maintained data when directed to do so by the Bureau.

A.5.6.7.4 The system shall maintain multiple versions of data and effective dates (start date and stop date) in machine-readable form for the adjudication of original payment requests, adjustments, and voids for all payment request types.

A.5.6.7.5 The system shall provide for all necessary expansion of any/all system maintained data elements and fields to accommodate expanding scope, new services, changing Bureau requirements, legislative mandates, or new technology, in a quick and flexible manner.

A.5.6.7.6 The system shall provide flexibility in automated systems to support changes in detailed business rules (e.g., payment requests edits) in a quick and accurate fashion through table-driven edits controlled by Bureau-authorized users.

A.5.6.7.7 The system shall balance all batch inputs, transactions processed, and outputs for all system-maintained data maintenance activity and transactions.

A.5.6.7.8 The system shall maintain as current all system-maintained data and ensure that only the most current, or most appropriate, information is used for processing in the TCMIS.

A.5.6.8 Data Retention

The following data retention requirements apply to all system-related data unless explicitly stated for a specific type of data:

A.5.6.8.1 The system shall provide access to all data used in Bureau-related business activities, including, but not limited to:

A.5.6.8.1.1 Claims processing

A.5.6.8.1.2 Payment requests

A.5.6.8.1.3 Managed care

A.5.6.8.1.4 Recipient eligibility

A.5.6.8.1.5 Provider eligibility

A.5.6.8.1.6 Third-party liability

A.5.6.8.1.7 Utilization

A.5.6.8.1.8 Data resulting from exchanges with CMS and other organizations

A.5.6.8.1.9 Reference

A.5.6.8.1.10 Data repository for electronic transactions

A.5.6.8.2 All TCMIS-related data shall be available online for thirty-six (36) months.

A.5.6.8.3 The Contractor shall ensure that data maintained by the system is properly and routinely purged, archived, and protected from destruction, as appropriate. Some data, as defined by the Bureau, shall never be purged, or shall be purged on a different schedule (i.e., lifetime procedure claims). All data purge schedules and procedures shall be approved in advance by the Bureau. Purged data shall be retained in electronic media specified by the Bureau. Data, including payment information, shall be archived according to Bureau standards.

A.5.6.8.4 Data retention for Protected Health Information shall comply with HIPAA Privacy Standards.

A.5.6.8.5 Data entered into, maintained, or generated by the system shall be retained and accessible according to federal and Bureau Requirements.

A.5.6.9 Turnover Plan Requirements:

The Contractor shall create a Turnover Plan for the TCMIS infrastructure and submit the plan no later than one (1) year from the start of full operations of the TCMIS, for Bureau approval. The Turnover Plan shall be updated and re-submitted to the Bureau no later than one (1) year prior to the end of the contract period for Bureau approval. The updated comprehensive Turnover Plan shall fully address the Contractor's approach to each of the Turnover Tasks in detail for each operational component of the TCMIS.

A.5.6.9.1 The Turnover Plan shall include the following deliverables:

A.5.6.9.1.1 Turnover approach

A.5.6.9.1.2 TCMIS requirement statement

A.5.6.9.1.3 Resource inventory, including staff, hardware and software that is needed to operate all components of the TCMIS

A.5.6.9.1.4 TCMIS software and files

A.5.6.9.1.5 Up-to-date TCMIS System, User, Operations, Procedures, and Training documentation

A.5.6.9.1.6 Turnover deliverables (e.g., progress reports, inventories, configuration diagrams)

A.5.7 Reporting and Outputs

A.5.7.1 Overview

In addition to the operation and maintenance of the TCMIS, the general scope of activities that shall be performed by the Contractor include reporting, such as federal and State reporting, Production and Distribution reporting and other reports, as requested by the Bureau. The outputs shall meet all federal and State reporting requirements and performance standards in Part 11 of the State Medicaid Manual, and shall provide the information necessary to assess compliance with federal certification and audit review standards. The outputs shall be produced on paper,

document imaging, online display, direct transmission, and electronic media, as directed by the Bureau.

A.5.7.2 Federal, State, Production and Other Reporting

Federal reporting is a core business process required by the Centers for Medicare and Medicaid Services (CMS) in the federal Department of Health and Human Services (HHS).

Federal reporting requirements and quarterly reports are part of data management. Federal reporting processes include generation and sending of the CMS-37 quarterly report, the CMS-21 and CMS-64 quarterly reports, the CMS MSIS -2082 annual report with quarterly updates and CMS-416 (EPSDT) quarterly and annual reports. Bureau of TennCare reporting includes reporting of financial expenditures from the STARS system and the A/R/A/P accounting application. The Bureau's Accounting and Finance unit is responsible for federal and State reporting functions. As of the Contract Start date, these reports are manually generated using a series of ad-hoc reports from the TCMIS and STARS systems. Information is entered into spreadsheets and final reports are produced.

The CMS-2082 report is a demographic and service utilization report compiled from TCMIS claims payment data. CMS offers a program that lets the states send in encounter data and CMS will compile the report itself. The program is called the MSIS project.

CMS-21, CMS-37, and CMS-64 reports contain expenditure and budget information compiled from the STARS and TCMIS systems and sent to CMS. The process for production uses an independent software program resident at TennCare Accounting and Finance. State budget information is received from the STARS system, translated into cost center codes, and loaded to the software application. Expenditure data from the TCMIS is compiled into cost center codes and received and applied to the software application. An output diskette is created using the software application and sent to the STARS system office for uploading/updating STARS. (NOTE: The Contractor should be aware that the STARS system may soon be replaced by the State's ERP system.)

The TennCare Management and Administrative Reporting Subsystem (MAR), which provides information retrieval and reporting that supports policy planning, program evaluation and decision-making, fiscal planning and control, federal reporting, and operational planning and control, shall be maintained by the Contractor

A.5.7.3 Reporting Contractor Requirements:

A.5.7.3.1 Provide management reporting to the Bureau for all aspects of the TCMIS. Assist the Bureau in definition and design of reports (a list of current standard reports, timeframes, and distribution is available).

A.5.7.3.2 Update and maintain all data elements as required by the federal MMIS General Systems Design and such additional elements as may be necessary for the Bureau to meet all federal data set requirements for federal reporting.

A.5.7.3.3 Produce ad hoc reports as requested by the Bureau.

A.5.7.3.4 Produce and assist the Bureau in definition and design of general system performance reports.

A.5.7.3.5 The TCMIS shall provide the ability for all output data, including reports, to be produced in PDF format for online viewing and printing. Where possible, the TCMIS shall utilize functionality already provided by the State infrastructure, such as Filenet and COLD for output reports.

A.5.7.3.6 The TCMIS shall provide the ability for all output data, including reports, to be imported into Microsoft Word and/or Microsoft Excel to ensure that text can be formatted, spell checked, and printed as a document.

A.5.7.3.7 The TCMIS shall provide for the creation and update of a report scheduling utility. Wherever possible, the TCMIS shall utilize functionality already provided by the State infrastructure.

A.5.7.3.8 The TCMIS shall provide the capability to download forms, enter and spell check data while online, and print, store, and/or transmit to remote locations.

A.5.7.3.9 The TCMIS shall provide the capability to manage current versions of forms and to keep metrics on the dates they are accessed.

A.5.7.3.10 The TCMIS shall utilize the State Data Center Printer (currently a Xerox 4635 & IBM 4000) for centralized printing of large, bulk printing requests for selected documents.

A.5.7.3.11 The TCMIS shall have the capability to capture pertinent data in 1-D and 2-D standardized barcode format for printing on system outputs such as correspondence, forms, letters, and notices.

A.5.7.3.12 The TCMIS shall provide for the “on demand” printing of documents and correspondence. In addition, the TCMIS shall have a facility for designing, creating, and editing “on demand” letters, correspondence, and notices.

A.5.7.3.13 Using the State Standard ad-hoc reporting tool, the TCMIS shall provide:

A.5.7.3.13.1 Access to pre-defined ad-hoc report templates (by functional area) for the selection of reporting criteria using a custom screen GUI interface (drop down boxes);

A.5.7.3.13.2 The ability for saving pre-defined ad-hoc reports for future use;

A.5.7.3.13.3 The ability to search and select from previously defined and saved ad-hoc reports; and

A.5.7.3.13.4 The ability to update a previously defined report and save for future use.

A.5.7.3.14 Produce Management Accounting and Reporting (MAR) Reports as required.

A.5.7.3.15 Produce Surveillance and Utilization Review (SUR) Reports as required.

A.5.7.3.16 Support all Management Reporting functions, files/database tables, and data elements necessary to meet the requirements of this Contract.

A.5.7.3.17 Produce TennCare medical assistance programs management reports within the time frames and according to the format, input parameters, content, frequency, media (e.g., hard copy, micro-media, electronic), and number of copies specified by the Bureau, and validate and deliver all outputs to the Bureau.

A.5.7.3.18 Ensure the accuracy of all reports before delivery to the Bureau.

A.5.7.3.19 Produce reports to allow management to monitor and compare program expenditures and budgeted amounts periodically, including, but not limited to, comparison of actual and budgeted funds, projections of revenue, and calculation of budget variances.

A.5.7.3.20 Identify non-participating EPSDT-eligible families in order to send notices about available services.

A.5.7.3.21 Produce reports to support financial planning and policy development, such as comparisons of past, current, and future financial trends.

A.5.7.3.22 Produce reports showing managed care-related expenditure information to allow management to generate financial reports on the per capita payments made to managed care entities.

A.5.7.3.23 Provide Medicare participation information on the level of medical assistance program expenditures for enrollees who also have Medicare coverage.

A.5.7.3.24 Provide information showing the extent that providers who are enrolled in the program are actually providing services.

A.5.7.3.25 Provide information showing enrollee participation and utilization of services indicating both payments and number of enrollees by aid category.

A.5.7.3.26 Provide information showing the geographic distribution of expenditures and enrollee participation at the county or other level to enable program management to monitor the statewide availability, comparability, and use of services.

A.5.7.3.27 Provide information to support institutional and managed care payment fee setting.

A.5.7.3.28 Provide information on provider credits and adjustments.

A.5.7.3.29 Provide dollar volume reports for Bureau budgets and projections.

A.5.7.3.30 Produce reports documenting expenditures on provider-submitted claims for cost-sharing.

A.5.7.3.31 Provide system performance reports.

A.5.7.3.32 Provide pended claims performance reports.

A.5.7.3.33 Generate, submit, and correct, if necessary, Medicaid Statistical Information System (MSIS) files and/or cartridges for CMS, according to CMS time frames and as defined by the Bureau.

A.5.7.3.34 Document reasons for CMS-identified errors on MSIS file validation, and implement changes approved by the Bureau to reduce the number of errors.

A.5.7.3.35 Provide a complete audit trail for management reporting processing. Provide reports and procedures for balancing reports internally (within the subsystem) and with related data from other subsystems.

A.5.7.3.36 Balance management report data to comparable data from other management reports for data reconciliation.

A.5.7.3.37 Follow up on Bureau inquiries resulting from the balancing procedures. Modify or add balancing procedures, as required by the Bureau.

A.5.7.3.38 Maintain, and provide to the Bureau, on request, complete and accurate documentation for the Management Reporting component of the TCMIS.

A.5.7.3.39 Provide and maintain complete user documentation for reporting systems that define the purpose of each report, specifically describes the definition of each reporting category, and data elements contained therein, their sources, the calculations involved in their determination, balancing instructions, the frequency of the report, and the report distribution and media. Include a master matrix of data elements indicating which reports contain a particular data element.

A.5.7.3.40 Update and maintain the Management Reporting User Manual for Contractor and Bureau personnel use.

A.5.7.3.41 Provide written report documentation describing each report produced and the systems specifications of each data element, including, but not limited to, a description of any internal or external balancing performed.

A.5.7.3.42 Provide basic and advanced training for the online Management Reporting functions.

A.5.7.3.43 Respond to Bureau requests for information concerning the data provided by the Management Reporting component of the TCMIS and respond to requests for electronic copies of reports.

A.5.7.3.44 Perform policy analysis under Bureau direction.

A.5.7.3.45 Maintain current and accurate information on all CMS reporting requirements.

A.5.7.3.46 Update system and operations documentation when system changes are made.

A.5.7.3.47 Make written recommendations on any area in which the Contractor or Bureau thinks improvements can be made.

A.5.7.3.48 Deliver management reports to appropriate Bureau staff within the time frames established by the Bureau.

A.5.7.3.49 Save final output files for at least twelve (12) months.

A.5.7.3.50 Respond to Bureau requests for information about the reports with a resolution no later than three (3) business days after the request.

A.5.7.3.51 Perform necessary corrections, rerun, verify, and distribute management reports within three (3) business days of problem identification.

A.5.7.3.52 Generate CMS reports by no later than six (6) weeks prior to the federal deadline.

A.5.7.3.53 Generate EPSDT notices for medical, dental, and vision services based on the Bureau periodicity requirements for medical, dental, and vision screening services, as specified by the Bureau.

A.5.7.3.54 Generate annual notices, or as specified by the Bureau, to nonparticipating, eligible families about EPSDT medical, dental, and vision services.

A.5.7.3.55 Generate Medicaid Eligibility Quality Control (MEQC) reports according to CMS time frames if required by the Bureau.

A.5.7.3.56 Maintain all data elements as required by federal regulations and any additional elements that are necessary to meet all federal data set requirements for federal reporting.

A.5.7.3.57 Ensure no disruption to federal reporting activities.

A.5.7.3.58 Generate any outputs necessary to meet federal reporting requirements.

A.5.7.3.59 Gather, analyze, present, submit, and explain financial and program data to Bureau staff as required for regular and intermittent reports and in response to special inquiries.

A.5.7.3.60 Maintain all financial and other program-related information necessary for reporting.

A.5.7.3.61 Support the generation of information for all federal reports and supporting data required by CMS, including, but not limited to:

1. CMS-21 Quarterly Report;
2. CMS-37 Quarterly Report;
3. CMS-64 Expenditures Report;
4. CMS-416 EPSDT Repost; and
5. CMS-2082 MSIS Annual Report with quarterly updates.

A.5.7.3.62 Meet the federal reporting requirements and performance standards in Part 11 of the State Medicaid Manual.

A.5.7.3.63 Generate federal reports in accordance with federally required timeframes and media.

A.5.8 TCMIS Infrastructure Documentation

The Contractor shall be responsible for providing complete, accurate and timely TCMIS infrastructure documentation. Any modifications to the TCMIS that are implemented into production shall not be considered complete until all systems, operations, procedures, user and training documentation have been updated, if applicable. Specific requirements are detailed in this Section.

A.5.8.1 <u>TCMIS Documentation Contractor Requirements:</u>

A.5.8.1.1 Any TCMIS documentation updates shall be provided within thirty (30) business days prior to Modified Operations Start Date.

A.5.8.1.2 The Contractor shall provide to the Bureau, up to ten (10) complete copies of the modified final version of the TCMIS infrastructure documentation. This includes at least four (4) hard-copy versions, with the remainder provided in the Bureau-approved electronic media and software format.

A.5.8.1.3 The Contractor shall be responsible for providing a complete copy of the operational TCMIS software and related materials, as well as the identification of all proprietary products used in the TCMIS, within thirty (30) business days prior to the Modified Operations Start Date.

A.5.8.1.4 Additional electronic copies of the TCMIS Documentation, or specified components thereof, shall be provided to the Bureau upon request. Such copies shall be provided within ten (10) business days of receipt of the request.

A.5.8.1.5 The Contractor shall ensure that the documentation repository copy of the TCMIS infrastructure documentation is current and shall incorporate all updates.

A.5.8.1.6 Documentation shall be accurate and contain a complete definition of current application features in production use.

A.5.8.1.7 TCMIS infrastructure documentation shall include business process flows and data models of the entire system and all subsystems and functions, showing all inputs, processes, programs, interfaces, program interrelationships, and outputs, depicting the Business Process Model.

A.5.8.1.8 When revisions are made to any component of the production TCMIS, the tasks shall not be considered complete until all associated documentation is updated. This includes systems, operations, procedures, user and training documentation.

A.5.8.1.9 The Contractor shall prepare TCMIS documentation updates according to State

or Bureau standards, incorporating all changes, corrections, modifications or enhancements of the TCMIS infrastructure.

A.5.8.1.10 The documentation updates shall be completed within ten (10) business days of the implementation of the change, unless otherwise agreed to by the Bureau.

A.5.8.1.11 The Contractor shall be responsible for supplying any copies of the TCMIS Systems Documentation required by CMS.

A.5.8.1.12 Documentation shall be kept current in conjunction with TCMIS modifications.

A.5.8.1.13 The Contractor shall be responsible for maintaining and updating each of the Bureau's copies as subsequent updates require.

A.5.8.1.14 The TCMIS documentation shall be accessible online, using the Contractor's Documentation software. Specific requirements pertaining to this feature are found in Enhancement #5, Section A.2.7.

A.5.8.1.15 The Contractor shall maintain tools and techniques used to manage the versions in all forms of the TCMIS documentation that requires updating, as modifications are completed.

A.5.8.1.16 Documentation shall be protected against unauthorized changes.

A.5.8.2 Required Documentation Standards

The TCMIS Infrastructure shall meet or exceed the following standards:

A.5.8.2.1 Be available and updated on electronic media (CD/DVD, file, cartridge) and available for online access by authorized users.

A.5.8.2.2 Be organized in a format that facilitates uncomplicated updating.

A.5.8.2.3 Revisions submitted for approval review shall be clearly identified.

A.5.8.2.4 System and subsystem narratives shall be understandable by non-technical personnel.

A.5.8.2.5 There are five (5) standard areas of TCMIS Documentation that the Contractor shall supply and maintain. They are as follows:

1) Systems Documentation:

Systems Documentation records all information regarding system and sub-system narratives containing functional descriptions and overviews such as data flow diagrams, programs, inputs/outputs, job streams, JCL/JIL, and hardware/software details.

2) Operations Documentation:

Operations Documentation records details pertaining to system operations functions, such as input/output used, forms/screens, reports, files, error and recovery processes, and internal controls.

3) User Documentation:

User Documentation records miscellaneous TCMIS comprehensive information used as reference data, to fully describe how data is used or interpreted, and should be understandable by non-technical personnel.

4) Procedures Documentation:

Procedures Documentation contains information that describes how a process is accomplished; such as mailroom processes, balancing procedures, data entry functions (e.g. address changes, on-line updates), or how to perform manual procedures.

5) Training Documentation:

Training Documentation includes sufficient information that is used for trainees to accurately and efficiently perform TCMIS related tasks, and is written so that a trained person can demonstrate expected proficiency.

A.5.8.2.6 During various stages of development, the Contractor shall provide associated documentation including requirements analyses; general systems design documentation, detailed system design documentation, test documentation, and documentation related to issues/resolution.

A.5.8.2.7 Provide Systems Documentation according to the following requirements:

A.5.8.2.7.1 The TCMIS Systems Documentation shall describe comprehensive detailed design with the use of technical components of the TCMIS.

A.5.8.2.7.2 Systems documentation shall be sufficiently detailed to allow Contractor and Bureau staff to complete their work correctly and more efficiently, or for use as a reference to understand logical processing.

A.5.8.2.7.3 The TCMIS Systems Documentation shall include narratives of the entire system, function, or process, describing each function and feature.

A.5.8.2.7.4 Systems Documentation shall include data flow diagrams showing data stores and flows, program names, and a description of the diagrams showing flow of major processes.

A.5.8.2.7.5 Systems documentation shall include hardware configuration diagrams showing the relationship between all data processing and communication equipment necessary to operate the TCMIS, including, but not limited to: local area networks, electronic media claims support networks, control units, remote job entry devices, data storage and transmission devices, printers, mainframe computers, PCs, and data entry devices.

A.5.8.2.7.6 Systems documentation shall describe and exhibit the workflow of the functional application, to aid in the understanding of predecessors and successors within the function.

A.5.8.2.7.7 Systems documentation shall cross-reference files used in each of the subsystems and across subsystems.

A.5.8.2.7.8 Systems documentation shall cross-reference data elements used in each of the subsystems and across subsystems.

A.5.8.2.7.9 The nomenclature used in the overview shall correspond to nomenclature used in subsystem documentation.

A.5.8.2.7.10 All subsystem documentation shall be referenced, and shall be consistent from the overview to the specific subsystems and between subsystems.

A.5.8.2.7.11 Systems Documentation shall include a listing of the platform's command language code that performs the process, including routines and edit criteria, if applicable.

A.5.8.2.7.12 For each subsystem/functional area, the Systems Documentation shall include:

Purpose

Subsystem name

Computer Programs

Inputs and Outputs, (including screens, forms, files)

Reports with samples, narrative descriptions, and explanation of use

Sources of inputs

Control data, if applicable

Job stream flows

JCL or JIL

Tables used

Cross reference listings or matrices of related elements

Operating procedures

Frequency and job scheduling parameters

Errors, error messages, and recovery procedures

Identification of reports, including control reports

A.5.8.2.7.13 For all screens, reports, files, and other outputs, the documentation shall include output definitions, including names, numbers, sources, destinations, examples, sort criteria, content definition, file specifications, file descriptions, and record layouts, wherever applicable.

A.5.8.2.7.14 Systems Documentation shall include all interfaces and interrelated entities that are included in the TCMIS infrastructure (e.g., FileNet, Oracle Financials, RRI, web application).

A.5.8.2.8 Provide Operations Documentation according to the following requirements:

A.5.8.2.8.1 Operations documentation shall define all technical procedures required to configure the application, perform batch processing, recover from failures, and otherwise support day-to-day business use of the application.

A.5.8.2.8.2 Operations documentation shall instruct operations staff on how to recover from error conditions, and possible resolutions of errors.

A.5.8.2.8.3 Operations documentation shall contain descriptions of error messages.

A.5.8.2.8.4 Operations documentation shall define all manual procedures necessary to perform the function.

A.5.8.2.8.5 Operations Documentation shall allow users to understand the workflow of the application, understanding predecessors and successors within the operation.

A.5.8.2.8.6 Operations documentation shall contain a description of the operation environment by general overview and by detailed description of each work unit, the flow of data, and the interaction between each functional area or work unit.

A.5.8.2.8.7 Operations documentation shall contain schedules and dependencies and shall be designed to support TCMIS monitoring ongoing activities.

A.5.8.2.8.8 Operations documentation shall include instructions for requesting reports or other outputs with examples of input documents and screens.

A.5.8.2.8.9 Operating procedures shall include instructions for reconciling internal reports for use in data or operations validation.

A.5.8.2.9 Provide User Documentation according to the following requirements:

A.5.8.2.9.1 User documentation shall describe use of the application within the TCMIS.

A.5.8.2.9.2 User documentation shall be non-technical and sufficiently detailed to allow associated staff to complete their work correctly and efficiently.

A.5.8.2.9.3 User documentation shall allow operations or program area staff to recover from input error conditions, by using the application documentation.

A.5.8.2.9.4 User documentation shall provide detailed information on procedures to allow the user to understand the logical workflow and the related process.

A.5.8.2.9.5 User documentation shall contain a data element dictionary (DED).

A.5.8.2.9.6 Each data element shall have a unique data element number.

A.5.8.2.9.7 Each data element shall have a standard data element name.

A.5.8.2.9.8 DED shall contain a narrative description of the data element.

A.5.8.2.9.9 DED shall contain a list of all data names used to reference the data element.

A.5.8.2.9.10 User documentation shall contain a table of valid values for each data element, if applicable.

A.5.8.2.9.11 User documentation shall contain the source, size, and type of each data element.

A.5.8.2.9.12 User documentation shall contain a table of contents, by subsystem, table, and element.

A.5.8.2.9.13 User documentation shall contain a list of programs using the data element, describing the use of input, internal, or output.

A.5.8.2.9.14 User documentation shall contain a list of files containing the data element.

A.5.8.2.9.15 A cross-reference to the corresponding Part 11 of the State Medicaid Manual (SMM) shall be included in the User Documentation.

A.5.8.2.10 Provide Procedures Documentation according to the following requirements:

A.5.8.2.10.1 Documented procedures for each functional application, and for each design structure shall include schedules, sequences, and frequencies of the tasks being performed, (e.g., batch processing cycles shall cover dependencies between jobs (predecessors and successors)).

A.5.8.2.10.2 Individual or manual tasks shall be documented. This documentation shall include an overall description of the processing task the job performs.

A.5.8.2.10.3 Documentation shall include procedures for recovering data to ensure recoverability in the event of processing failure.

A.5.8.2.10.4 Procedure shall be documented for certain processes where manual interactions are required (e.g. overrides, decision points), with associated criteria, and shall include information pertaining to the destination links with other processes.

A.5.8.2.10.5 Procedures documentation shall include data entry or file maintenance instructions, including error handling.

A.5.8.2.10.6 Documentation shall include detailed mailroom procedures for processing all TennCare mail.

A.5.8.2.10.7 Documentation shall include detailed procedures for processing undeliverable correspondence and other returned mail.

A.5.8.2.10.8 Documentation shall include detailed procedures for processing Medical Eligibility (ME) packets.

A.5.8.2.10.9 Documentation shall include detailed procedures for performing all address changes.

A.5.8.2.10.10 Documentation shall include detailed procedures for resolving suspended claims.

A.5.8.2.10.11 Documentation shall include detailed processes relating to customer service support functions.

A.5.8.2.10.12 Documentation shall include detailed procedures relating to Third Party Liability functions, including questionnaires, and associated payment recovery processes.

A.5.8.2.10.13 Documentation shall include detailed procedures relating to production Server support.

A.5.8.2.10.14 Documentation shall include detailed procedures relating to non-production Server support.

A.5.8.2.11 Provide Training Documentation according to the following requirements:

A.5.8.2.11.1 Online accessibility of the documentation shall be shown and demonstrated to authorized employees responsible for performing various tasks associated with operating or conducting training on the TCMIS infrastructure, as well as those executing tests. The Bureau and Contractor staff shall also have access to the hard-copy versions, if needed.

A.5.8.2.11.2 The Contractor shall provide training plans to detail activities related to procedures for using the TCMIS functions needed to perform job responsibilities. The plan shall describe training strategies including methods, materials, audience, and timing.

A.5.8.2.11.3 Training plans shall be submitted to Bureau staff in sufficient time to allow for approval one (1) month prior to first user acceptance tests when implementing new enhancements, or as needed.

A.5.8.2.11.4 Training documentation shall describe tasks relative to the operation or maintenance, done on a day-to-day basis.

A.5.8.2.11.5 The training documentation shall include ”how-to” instructions on navigating each component within the TCMIS infrastructure.

A.5.8.2.11.6 Training documentation shall include screen-shots, input/output samples, reports or notices, and all other information related to specific data if needed for comprehension (e.g., code representation/interpretations).

A.5.8.2.11.7 Training documentation shall include providing training manuals in form, quantity, distribution, and substance as required by the Bureau.

A.5.8.2.11.8 Training manuals shall be written and organized so that users not trained in data processing will understand how to access screens, read and interpret reports, and perform user functions.

A.5.8.2.12 Provide Testing Documentation.

A.5.8.2.13 The Contractor shall provide test schedules, work plans, description of deliverables, resource requirements, and testing management approach.

A.5.8.2.14 The Contractor shall provide detailed test plans including expected outcomes of test transactions.

A.5.8.2.15 Test documentation shall include samples of test data used and test results,

including screen prints and reports.

A.5.8.2.16 Test documentation shall include retest documents and corrective action measures to resolve issues.

A.5.9 TCMIS Infrastructure Documentation Deliverables

A.5.9.1 Documentation Deliverables:

A.5.9.1.1 The Contractor shall provide documentation software as detailed under Section A.2.7, Enhancement #5.

A.5.9.1.2 The Contractor's documentation deliverables shall contain the standards and content as required for the TCMIS Infrastructure Documentation as depicted in Section A.5.8 and shall include Systems, Operations, User, Procedures, Training, and Testing documentation and shall be complete and presented to the Bureau within thirty (30) days prior to the Modified Operations Start Date.

A.5.9.1.3 The Contractor shall be responsible for the production and distribution of all updated electronic copies, of the TCMIS infrastructure documentation to ensure that they are current.

A.5.9.1.4 The Contractor shall maintain the online version of the documentation, updating each component as ongoing updates to the TCMIS require.

A.5.9.1.5 The Contractor shall deliver all materials and information needed for Certification review.

A.6 Staffing

A.6.1 Facilities Manager Staffing Contractor Requirements

Upon the Effective Date of the Contract, the Contractor shall have sufficient staff to operate the baseline system and business processes contained in the Contract. It is the intent of TennCare to have the modified TCMIS fully operational, by the Modified Operations Start Date. The transition from the baseline staffing levels on the Effective Date of the Contract to the Modified Operations staffing levels shall be completed by the Modified Operations Start Date.

All personnel shall be the employees or contracted staff of the Contractor and shall be fully qualified to perform the work required in this Contract. The Contractor shall ensure that all staff members possess the necessary technical background, education, and skills to perform in the various environments and capacities necessary to support the TCMIS infrastructure.

The Contractor shall have total responsibility for hiring and management of any and all Contractor staff as determined necessary to perform the services in accordance with the terms of this Contract and shall provide a proposed Resource Level Staffing Plan for review and approval by TennCare. The Plan shall include at a minimum, key staff identified below and corresponding job descriptions. The Contractor's failure to provide and maintain key staff may result in liquidated damages as set forth in Attachment B.

The Bureau shall have the absolute right to approve or disapprove the Contractor's and any subcontractor's staff, or to require the removal or reassignment of any Contractor employee or subcontractor personnel found unacceptable to the Bureau for work done under this Contract only.

The Contractor shall provide the technical experts and/or high level management, herein referred to as “Key Personnel,” necessary for TCMIS project operations, which are detailed in Section A.6.2. The Contractor shall demonstrate to TennCare that Contractor has the Key Personnel to perform the Contract. Therefore, the Contractor shall comply with the below staff requirements.

The Contractor shall have the general discretion to assign Maintenance and Modifications staff to maintenance support as required to complete requests timely and will coordinate with the Project Director to address changes in Bureau needs and priorities. The Contractor shall reallocate staffing resources based on current TennCare program needs and current TennCare structure. Additionally, reallocations may be requested of the Contractor by TennCare management. The parties recognize that the timely completion of maintenance and modifications activities requires timely cooperation from the Bureau for requirements validation, test validation and post-implementation review of Maintenance and Modification requests. The Contractor shall be held harmless for non-compliance with performance standards related to the processes performed by the individuals re-assigned to other needs by the Bureau.

A.6.2 Key Staff Requirements

The Contractor shall notify the Bureau, in writing, of any change in Key Personnel at least thirty (30) days prior to the change or within one business day of Contractor receiving notice from the employee, whichever is later. The Contractor shall provide the Bureau with a resume of any key member of its staff or subcontractor's staff assigned to any aspect of the performance of this Contract. If the key personnel is not on-site and/or working on TCMIS, than Contractor shall deliver a statement signed by the key personnel employee that s/he has agreed to a possible relocation for the TCMIS project. Should key personnel end their employment with the Contractor or refuse to work on the TCMIS project, then replacement personnel shall be of similar or greater experience and approved by TENNCARE. Unless otherwise approved by the Bureau, failure to submit resume of an appropriately qualified individual within 60 days may result in liquidated damages as set forth in Attachment B. If the candidate is rejected by the Bureau, the sixty day period begins on upon receipt of the rejection by the Contractor.

Key Personnel are defined as:

a. Account Manager

b. Deputy Account Manager

c. Project Management Office (PMO) Director

d. Operations Processing Manager

e. Computer Operations Manager

f. TCMIS Systems Manager

g. Lead Database Administrator

h. Enhancement Project Manager

The roles of the Deputy Account Manager and the Enhancement Project Manager are not required to be filled on the Effective Date of the Contract. However, the Contractor shall fill these positions as quickly as reasonably possible and no later than the Modified Operations start date.

The Key Personnel roles are described below.

A.6.2.1 Account Manager

The Account Manager directs and coordinates overall activities and shall be responsible for the complete TCMIS account including the administration of ongoing support and management of Start-Up activities, Operations and Enhancement implementations. This individual shall be responsible for managing all facets of this Contract, which shall include the following responsibilities:

a. Be dedicated to meeting the expectations and requirements of the TCMIS Contract.

b. Strive to ensure Bureau satisfaction for TennCare business initiatives and solutions.

c. Develop and maintain a long-term account relationship with Facilities Management staff, Bureau staff and others as required.

d. Maintain regular contact with other account executives and managers as required.

e. Be responsible for account planning and project tracking.

f. Work proactively to address and resolve issues.

g. Execute TennCare business plans within the allocated budget and resources.

h. Administer or directly supervise the performance evaluations of subordinates, especially regarding aspects of customer satisfaction values.

A.6.2.2 Deputy Account Manager

The Deputy Account Manager shall work directly with the Account Manager to assist in overseeing all tasks associated with managing the TCMIS account.

A.6.2.3 Project Management Office (PMO) Director

The Project Management Office Director shall coordinate overall activities associated with enhancements, applications development and support. Other responsibilities include:

a. Work with other resources to develop and adhere to project implementation plan.

b. Disseminate information to associates and stakeholders.

c. Direct workers in problem resolution and monitoring.

d. Maintain records, prepare and distribute reports.

e. Collaborate with other management to meet Bureau and Contractor objectives.

f. Track and report on the progress of testing and serve as liaison to Bureau staff and Contractor's systems staff.

A.6.2.4 Operations Processing Manager

a. Interface with other Contractor management staff and Bureau staff on production or testing issues

b. Manage processes when testing and implementing interrelated programs/projects.

c. Monitor and maintain operations processing.

d. Participate in implementation project team meetings to ensure that standards and procedures are adhered to, and also to ensure recoverability.

A.6.2.5 Computer Operations Manager

The Computer Operations Manager shall be responsible for the Computer Operations staff, ensuring that all tasks are performed as required by the Bureau. Other responsibilities include:

a. Maintain daily records of communicated problems, troubleshooting, and remedial action taken.

b. Supervise and coordinate workers for computer operations and monitoring.

c. Supervise and coordinate equipment and software installation.

d. Assist in testing software, hardware and peripheral equipment and provide assistance in diagnostics when needed.

e. Consult with management and system staff to clarify processing related issues.

f. Work with system staff to compose instructions for operations guidance, and submit documentation updates to documentation staff.

g. Assist computer operators or other staff in resolving problems relating to computer operations.

h. Prepare records and reports.

i. Monitor daily operations to ensure that Contract requirements are met.

j. Train subordinates in computer operations responsibilities.

A.6.2.6 TCMIS Systems Manager

a. Interact with systems staff and Bureau staff to monitor daily status and schedule.

b. Monitor processes and keep Bureau and Contractor management informed of errors or scheduling conflicts.

c. Manage the implementation of modifications or new developments.

d. Identify and assign technical leaders and team members within each functional area.

e. Plan and monitor each functional team’s activities.

f. Track progression of plans to resolve issues.

g. Ensure that tasks and due dates are met according to project schedule.

h. Advise members of functional teams of possible inter-related tasks that may create technical issues.

i. Produce project management reports as required by the Bureau.

A.6.2.7 Lead Database Administrator

The Lead Database Administrator will be the primary contact for technical assistance and training to users of the interChange infrastructure. Other responsibilities include:

a. Design, install, monitor, maintain, and regulate production and test databases while ensuring high levels of data accessibility.

b. Work with application development or modification staff to develop or modify database architectures and coding standards.

c. Work with staff to assist them in understanding functions affected, when changes are done, relating to databases.

d. Create models for new database development and/or changes to existing databases.

e. Respond to and resolve database access and performance issues.

f. Monitor database system details within the database, including stored procedures, execution time, and implement improvements for efficiency.

g. Optimize and allocate physical data storage.

h. Support the creation of required reports for needs of the Bureau.

i. Perform database transaction and security audits.

j. Provide guidance to Contractor or Bureau staff related to database access or issues.

k. Develop data models, ensuring that data elements are described including how they are used.

l. Code data base descriptions and specify identifiers used in the iC infrastructure, or direct others in coding descriptions.

m. Review procedures in systems manuals, data element dictionary, and other documentation and submit updates to documentation staff.

n. Confer with coworkers to determine scope and limitations of project.

o. Specify user and user access levels.

p. Investigate and resolve computer software and hardware issues.

q. Respond to inquiries in writing, by phone, or in person concerning the use of hardware and software including printing, programming, and operations.

A.6.2.8 Enhancement Project Manager

The Enhancement Project Manager shall provide leadership and direction for the various tasks involved for each enhancement implemented. Responsibilities include:

a. Ensure that adequate qualified personnel resources are assigned that shall be required to perform activities for each of the enhancements.

b. Develop a Work Plan, detailing activities and timelines associated with each enhancement.

c. Attend Bureau meetings as required.

d. Assure that all enhancement activities are performed according to the Work Plan.

e. Coordinate priorities and scheduling with Bureau staff.

f. Monitor all project dates.

g. Ensure that each enhancement is submitted for documentation and training activities, if needed.

A.6.3 Maintenance and Modifications Staffing Contractor Requirements

The Contractor shall provide staffing to meet the requirements and performance measures defined within the Contract. Additionally, the Contractor shall provide, at a minimum, the staffing levels stated in this section for Maintenance and Modification staff (Full Time Equivalent). The Contractor shall, at a minimum, have at least ninety-five percent (95%) of the total Maintenance and Modifications positions, as required to fulfill the scope of services specified in this Contract and reported monthly. Unless otherwise approved by the Bureau, failure to meet this standard may result in liquidated damages as set forth in Attachment B. If a situation arises in which the standard is met but vacancies in a particular category or role become a concern, the Bureau may require the Contractor to fill a vacant position in a reasonable period of time.

Staff to be included within the Maintenance and Modification Staff shall include, but not be limited to, the job categories and quantity of staff as defined in the following table:

Category	Minimum Staff At Contract Effective Date	Minimum Staff At Modified Operations Start Date
Systems	49	84
Business Services	22	40
Project Management	16	33
Infrastructure	15	23
DBA	0	2
Leadership	2	6
Total	104	188

Systems roles include Information Specialist, Information Analyst, Information Associate, Reporting Specialist and Application Architect. This job category shall be at least seventy-five percent (75%) on-site and ninety-five percent (95%) dedicated (no more than five percent (5%) leveraged), unless otherwise approved by the Bureau.

Business Services roles include Business Services Analyst, QA Specialist (tester), Process Analyst, and Dashboard Analyst. This job category shall be at least ninety-five percent (95%) on-site and one hundred percent (100%) dedicated (not leveraged), unless otherwise approved by the Bureau.

Project Management roles include Project Manager, Project Analyst, Technical Writer, Work Planner, Release Coordinator, Trainer, Reference Analyst, Dashboard Analyst and Change Management Coordinator. This job category shall beat least ninety-five percent (95%) on-site and one hundred percent (100%) dedicated (not leveraged), unless otherwise approved by the Bureau.

Infrastructure roles include Systems Administrator, Systems Associate, Infrastructure Specialist, Infrastructure Architect, Server Support (Production and Non-Production), Security and Computer Operations. This job category shall be at least eighty percent (80%) on-site and one hundred percent (100%) dedicated (not leveraged), unless otherwise approved by the Bureau.

DBA roles include Data Base Administrator and Data Base Associate. This job category shall be at least seventy-five percent (75%) on-site and ninety-five percent (95%) dedicated (no more than five percent (5%) leveraged), unless otherwise approved by the Bureau.

Leadership roles include formal leaders, excluding Key Staff, with responsibility for Maintenance and Modification staff. This job category shall be one hundred percent (100%) on-site and one hundred percent (100%) dedicated (not leveraged), unless otherwise approved by the Bureau.

Roles that are established to support Maintenance and Modifications through the remainder of the Contract and that are staffed shall be included in the measurement of Maintenance and Modifications headcount for a given period, even though they may also be supporting Enhancement activity for the same period. Roles that are established to support an Enhancement that will end upon completion of that Enhancement shall not be included in the measurement of Maintenance and Modifications headcount; instead, they shall be measured against the staffing plan for each Enhancement.

For planning purposes, the anticipated breakout of the staffing levels by role are outlined in the table below. However, the actual breakout of the staffing roles may differ to adapt to the changing needs of the Bureau, as noted in A.6.1.

Category	Role	Estimated Modified Operations Breakout by Role

Systems Engineer	Information Specialist/Analyst	78
Systems Engineer	Application Architects	3
Systems Engineer	Reporting Specialist	3
Project Management	Work Planner	1
Project Management	Technical Writer	5
Project Management	Release Coordinator	1
Project Management	Project Manager	9
Project Management	Project Analyst	6
Project Management	Trainer	2
Project Management	Dashboard Analyst	4
Project Management	Process Analyst	2
Project Management	Reference Analyst	2
Project Management	Change Management Coordinator	1
Leadership	Technical Delivery Team Manager	4
Leadership	BSA/Testing Manager	1
Leadership	Documentation/Training Manager	1
Infrastructure	Systems Administrator/Associate	6
Infrastructure	Infrastructure Specialist Senior	3
Infrastructure	Computer Operator	2
Infrastructure	Infrastructure Architect	1
Infrastructure	Security	5
Infrastructure	Server Support	5
Infrastructure	General Support Clerk	1

DBA	Data Base Associate	1
DBA	Data Base Administrator	1
Business Services Analyst	QA Specialist	25
Business Services Analyst	Business Services Analyst	15
Total		188

The Maintenance and Modifications personnel roles are described below.

A.6.3.1 Applications Architect

a. Guide the design, development and support of technical software solutions

b. Research and recommend new technologies, standards and tools

c. Coordinate with the Bureau to assist in establishing and executing the technology strategy

A.6.3.2 Information Specialist

a. Work with Business Services Analysts and Information Analysts when maintaining and supporting TCMIS data and iC infrastructure.

b. Coordinate the design, development, and implementation of enhancements or system modifications to support all modifications to the TCMIS.

c. Work with Bureau staff to define project scope, project deliverables, and implementation dates.

d. Research, analyze, and make recommendations pertaining to the implementation of new processes, tools, and technologies.

e. Update, develop, and enforce standards and procedures.

f. Perform duties associated with configuration management to ensure the integrity of source code control.

g. Monitor and ensure resolutions of performance issues.

h. Assist leadership in comprehending or planning for new IT solutions or functions.

A.6.3.3 Information Analyst

The job category identified as “Information Analyst” may include responsibilities traditionally associated with programmers, programmer analysts, systems analysts, and senior systems analysts.

a. Primary responsibility is for delivering solutions for WR/SCR work.

b. Design and construct IT solutions, defining project scope, plans and deliverables.

c. Collaborate with others, and work with BAs to ensure that business requirements are met.

d. Work with BA to develop specifications.

e. Develop technical detailed design documentation for SCRs.

f. Provide technical assistance to BA in System Testing.

g. Provide technical assistance to End User/TCIS for User Acceptance Testing.

h. Perform estimates for WR/SCRs.

i. Work to meet customer's expectations in prioritization.

A.6.3.4 Ad Hoc Reporting Specialist

a. Support the Bureau by using automated inquiry tools to secure answers to TennCare business questions

A.6.3.5 Server Support

a. Support the Non-Production TCMIS environments for Development, Training and Test/UAT Servers located outside of the OIR data center. This includes all the Unix and Wintel servers located at 310 Great Circle Road.

b. Support the Production Windows Servers located outside of the OIR data center. This includes the Optical Character Recognition claim capture Servers located at 310 Great Circle Road, and the NICE Server at the Tennessee Prison for Women. In addition, this includes support for the Mailroom imaging stations at 310 Great Circle Road, except for the PC hardware and PC OS

A.6.3.6 Security

a. Supplement the TennCare IS security team for identity and access administration

A.6.3.7 Business Services Analyst (BSA or BA)

The job category identified as "Business Services Analyst" may include responsibilities traditionally associated with business analysts, systems analysts, and senior systems analysts.

a. Work directly with requestor to ensure that business specifications are defined.

b. Formulates business scope and objectives, serving as the subject matter expert in various functional areas.

c. Serve as liaison between the Bureau staff and technical solutions staff to identify business processes and systems requirements.

d. Develop test scenarios and execute test cases to ensure that changes meet business requirements.

e. Define data requirements and gather and validate information.

f. Perform program and system validation and testing.

g. Work to define needed program changes to resolve operating problems.

h. Specify computational data and methods to be applied develop test data and define expected results.

A.6.3.8 Technical Delivery Team Manager (TDTM)

a. Responsible for all work in their functional areas.

b. Primary focuses are:

Coordination with Project Managers;

Day-to-day maintenance of the system; and

Development of, and adherence to, processes and procedures.

c. Coordinate with the Project Manager to ensure that resources are available for WR/SCR work based upon prioritization.

d. Provide overall status on functional areas.

A.6.3.9 Business Analysis and Testing Manager

a. Plan, direct and coordinate business relations activities to develop user requirements and implement business solutions that meet customer needs, ensuring that business objectives and requirements are achieved

b. Advise staff on priorities, technical issues and administrative policies and procedures.

c. Review and evaluate the definition analysis and testing of business solutions

d. Review task, status and progress schedules to promote accurate, timely and cost effective completion

e. Provide guidance and support in the decision process between the client and internal support groups

f. Direct the management of the test case libraries

A.6.3.10 Project Manager (PM)

a. Responsible for interfacing with the Business User on status, prioritization and resolving questions

b. Report on status of prioritized items

c. Manage scope and definition processes for SCRs

d. Give direction, when needed, to Information Specialists and Information Analysts

e. Work with BA to ensure business needs are met

f. Work with Information Specialist, Analysts and TDTM to ensure that technical specifications are met.

A.6.3.11 Project Analyst

a. Provide system support and research analysis for project management and customer support.

b. Provide specifications for systems modifications based on Bureau requirements.

c. Assist BAs to analyze requirements and propose appropriate technical solutions which include software, hardware and interface or network solutions.

d. Coordinate maintenance activities to resolve issues to fulfill Bureau requirements.

e. Capture and report on project metrics such as schedule and cost performance, project close out and post implementation evaluation status or issues.

f. Establish project schedules, resource plans and project budgets.

g. Work closely with TennCare's PMO to provide project planning analysis, providing project plan documentation (e.g., scope, resources, requirements, and schedule).

A.6.3.12 Reference Analyst

a. Coordinate with the Bureau to establish a process for reference file management, with appropriate Bureau review and approval

b. Coordinate timely submission of recommendations for Systems upload of annual code updates

c. Monitor and research the Register, CMS and other sources for potential code changes

d. Coordinate with Bureau staff to research code change policy and implications related to system processing for inclusion in the recommendation packet

d. Submit recommendations for added, changed or deleted codes based on research and best practices to the Bureau Policy Review Board for approval

e. Schedule Policy Review Board meetings, as required

f. Perform timely loading of Bureau authorized new codes into the TCMIS and document QC results of changes completed.

A.6.3.13 Dashboard Analyst

a. Measure, analyze and compile complex quality and performance statistics to report requested metrics and findings to management

b. Plan, coordinate and execute quality reviews to assess contract obligations and client expectations

c. Use dashboard and management reporting tools to present information clearly and succinctly.

d. Coordinate with Bureau staff to load Bureau-provided content to the dashboard tools

e. Provide assistance as needed to users of the dashboard application

A.6.3.14 Process Analyst

a. Support business function analysis

b. Evaluate current workflow of business processes

c. Research and coordinate with subject matter experts to collaboratively identify business process improvement opportunities using established quality and process frameworks

d. Schedule executive review meetings, as necessary, to present and secure approvals for the to-be state of the business process

e. Document the new business process model using a UML modeling tool and publish the documentation on Bureau documentation repositories

A.6.3.15 Trainer

The Training Coordinator shall be responsible for providing training curriculum and materials on the use, processes and functions, and the navigation features of the TCMIS infrastructure. The training shall be provided to TCMIS users, leadership, Contractor staff, and others as designated by the Bureau. Other responsibilities include:

a. Coordinate and produce deliverables used in training, such as handouts, screen-shots, and input/output samples.

b. Evaluate training and performance support materials to ensure that they are specific for the business process and up-to-date.

c. Work with Documentation staff to ensure that the documentation information is correct and current.

d. Coordinate and participate in user training sessions of software tools managed by the Contractor.

e. Document feedback from participants and develop improvement strategy.

f. Document and report inaccuracies and inconsistencies to Q/A staff.

g. Produce periodic status report giving accountability of training activities.

h. Demonstrate procedures being taught for hands-on training sessions.

i. Respond to questions.

j. Design, develop and conduct training programs to instruct employees and users.

k. The Senior Trainer will also support the development of training materials.

l. Develop and maintain the annual Training Plan

A.6.3.16 Infrastructure Architect

a. Guide the design, development and support of technical solutions

b. Research and recommend new technologies, standards and tools

c. Coordinate with the Bureau to assist in establishing and executing the technology strategy

A.6.3.17 Database Administrator

The Database Administrator will provide technical assistance and training to users of the interChange infrastructure. Other responsibilities include:

a. Design, install, monitor, maintain, and regulate production and test databases while ensuring high levels of data accessibility.

b. Work with application development or modification staff to develop or modify database architectures and coding standards.

c. Work with staff to assist them in understanding functions affected, when changes are done, relating to databases.

d. Create models for new database development and/or changes to existing databases.

e. Respond to and resolve database access and performance issues.

f. Monitor database system details within the database, including stored procedures, execution time, and implement improvements for efficiency.

g. Optimize and allocate physical data storage.

h. Support the creation of required reports for needs of the Bureau.

i. Perform database transaction and security audits.

j. Provide guidance to Contractor or Bureau staff related to database access or issues.

k. Develop data models, ensuring that data elements are described including how they are used.

l. Code data base descriptions and specify identifiers used in the iC infrastructure, or direct others in coding descriptions.

m. Review procedures in systems manuals, data element dictionary, and other documentation and submit updates to documentation staff.

n. Confer with coworkers to determine scope and limitations of project.

o. Specify user and user access levels.

p. Investigate and resolve computer software and hardware issues.

q. Respond to inquiries in writing, by phone, or in person concerning the use of hardware and software including printing, programming, and operations.

A.6.3.18 Database Associate

The Database Associate shall assist the Database Administrator to provide technical assistance and training to users of the interChange infrastructure. Some responsibilities include:

a. Assist in the design, installation, monitoring, and maintaining production and test databases while ensuring high levels of data accessibility.

b. Assist in training and responding to questions.

c. Assist in the investigation and resolution of computer software and hardware issues.

d. Assist in creating models for new database development and/or changes to existing databases.

e. Support the creation of required reports for needs of the Bureau.

A.6.3.19 Infrastructure Specialist

a. Work closely with other systems staff and analysts to ensure that the total infrastructure meets the Bureau's requirements and is technically proficient.

b. Serve as technical advisor on system design.

c. Communicate alternatives to management and recommend alternative technical solutions.

d. Serve as liaison between Contractor systems staff and the Bureau to ensure that all changes or specifications are communicated to all associated entities.

e. Ensure that any modifications or enhancements have all internal and external interfaces identified, and that associated processing of the interfaces is coordinated among all functional areas.

f. Perform tasks necessary to ensure that all maintenance, modifications and enhancements of the TCMIS are in accordance with accepted standards.

g. Plan and coordinate a cross-functional team's activities to manage and implement project and/or interrelated programs.

h. Counsel members of cross-functional teams to accomplish project/program goals to meet projected schedules.

i. Assist in the resolution of technical/operational issues.

j. Provide technical leadership on infrastructure system design compatibility with new integrated systems implementation.

k. Assist in the data engineering design functions to provide knowledge in the design, development, and implementation support for optimization of TCMIS infrastructure.

A.6.3.20 Systems Administrator

a. Ensure integrity by evaluating, implementing, and managing software/hardware solutions needed for operational support.

b. Implement standards and procedures for hardware and software.

c. Serve as liaison between the Bureau and other entities to resolve network and hardware problems.

d. Recommend solutions to enhance functionality.

e. Participate as needed, in the implementation of enhancements or modified systems functions.

f. Provide user or staff orientation on network operations, hardware, or software.

g. Provide complete control and accounting of all data received, stored, used or transmitted by the Contractor to assure administrative, physical, and technical security of the data.

A.6.3.21 Computer Operator

a. Operate and monitor computer and peripheral equipment as required.

b. Observe and document error messages, job step executions, faulty output or machine interruptions.

c. Determine and communicate source of computer problems (user access, hardware, software).

d. Advise appropriate staff of computer problems.

e. Serve as liaison between Contractor IT staff and Computer operations staff to resolve problems.

f. Document details of issues and resolutions.

g. Contact appropriate staff to resolve job execution issues.

h. Make procedural or operational corrections as necessary.

i. Facilitate the use of input data as needed for job executions, (e.g., data or file overrides, parameter dates, and control numbers).

A.6.3.22 Quality Analysis (QA) Specialist

a. Perform quality assessment activities including quality control and quality auditing.

b. Validate that deliverables are complete, accurate, and ensure that standards are met or exceeded.

c. Conduct quality reviews in all service delivery areas.

d. Document and report inaccuracies and inconsistencies to management.

e. Make recommendations for improvements.

f. Ensure that corrective actions are implemented.

A.6.3.23 Documentation and Training Manager

a. Direct tasks associated with composing TCMIS Systems, operations, training, procedures and user documentation.

b. Assign tasks to technical writers and trainers.

c. Ensure consistency and accuracy in technical, user, and project documentation using established standards.

d. Work with Quality Assurance Specialists to ensure that all documentation is accurate, complete, and thoroughly depicts the business and technical information.

e. Ensure that the documentation of user or technical procedures and processes is accurate, clear, consistent, organized, and complies with accepted standards.

f. Ensure that documentation is delivered on time and in standard format.

g. Communicate with all other staff to ensure that any TCMIS revisions or updates are conveyed to be included for documentation updates.

h. Provide status of assignments to management.

A.6.3.24 Technical Writer

a. Analyze and interpret technical information to compile and record user and technical documentation.

b. Work with business services analysts and information specialists to produce quality documentation that is coherent and reliable.

c. Write text to compose documentation of the TCMIS infrastructure and inter-related business and operation functions.

d. Respond to all requests for documentation updates.

e. Provide weekly assignment status report to Documentation Project Manager.

f. Receive and track requests for documentation updates

g. Provide assistance to users on documentation issues with Project Workbook, or other documentation software, navigation.

A.6.3.25 General Support Clerk

a. Assist in administrative matters.

b. Maintain and distribute records or reports associated with contractual requirements.

c. Assist in developing and documenting guides, reports, manuals, or procedures.

d. Compile information for management reports.

e. Sort and distribute reports or work orders.

f. Work in document control to open mail; sort, batch, photocopy, scan and/or microfilm documents; enter data, file, and store and retrieve documents associated with the TCMIS.

g. Work to prepare outgoing mail including enrollee notices, remittance advices, and provider manuals.

h. Research and resolve questions or management requests.

A.6.3.26 Change Management Coordinator (CMC)

a. Facilitate the Change Control Board (CCB) meetings.

b. Coordinate all change requests.

c. Prepare agenda and minutes for CCB meetings.

d. Utilize TeamTrack and manage TCMIS changes with the Bureau.

e. Prepare reports documenting status of prioritized items.

A.6.3.27 Release Coordinator (RC)

a. Track SCRs/WRs and project release dates/numbers.

b. Ensure that all items moved to override are assigned to a release to move out of override.

c. Ensure that all release items are documented and secure approval from the Bureau.

d. Prepare release verification plans.

e. Manage the override directory.

A.6.3.28 Work Planner (WP)

a. Develop and maintain plans for each moderate to major WR/SCR.

b. Develop and produce metrics to report on progress.

c. Develop and produce look-ahead reporting.

d. Develop and produce what-if impact analysis for prioritization changes.

e. Maintain the resource pool.

f. Maintain overall work schedule.

A.6.4 Operations Process Staffing

The Contractor shall provide, at a minimum, the staffing levels stated below for Mailroom, Provider Support Service, Data Entry and Imaging staffing (Full Time Equivalent) as needed to perform duties as required or to support this Contract. The Contractor shall, at a minimum, have at least ninety-five percent (95%) of the total Operations Process positions, as required to fulfill the scope of services specified in this Contract. Unless otherwise approved by the Bureau, failure to meet this standard may result in liquidated damages as set forth in Attachment B.

Category	Number of Staff (FTEs)
Mailroom	12
Provider Support	26
Data Capture	23
Total Operations Process	61

A.6.4.1 Mailroom Services

The Mailroom team shall be staffed as follows:

Role	Number of Staff
Mailroom Clerk	11
Mailroom Supervisor	1

A.6.4.1.1 Mailroom Clerk Role:

a. Receive, sort, screen and distribute mail;

b. Batch, index, image and enumerate documents;

c. Facilitating Claims record management; and

d. Perform Courier duties for collecting and delivering various materials and documents to and from multiple destinations.

A.6.4.2 Provider Support Services

The Contractor shall be required to provide staff to perform provider support functions. These staffing levels shall be evaluated by the Contractor and the Bureau on a quarterly basis to ensure that adequate staff are present to meet the call volumes.

Within the Provider Support team shall be staffed as follows:

Role	Number of Staff
Provider Support Team Leader	1
QA Coordinator	1
Customer service representatives (CSR)	3
Suspense Processing	6
Finance	6
File Maintenance	9

The Provider Support Service staffing level assumes that each customer service representative is able to respond to eight (8) to ten (10) calls per day. At a minimum, representatives shall provide status information relating to issues. This status may be that the problem is fixed, the resolution has been identified and shall be completed within a certain timeframe, or the Contractor is awaiting direction from the Bureau on which action is necessary.

The Suspense Processing staff shall support the resolution of at least eight thousand, one hundred (8,100) claims per week. However, the Contractor shall allow for a fluctuation of volumes up to twenty thousand (20,000) claims per week. In the event that policy changes or other external factors cause an increase in the weekly suspense volumes, the excess volume shall be invoiced by the Contractor by the quarterly Excess Operations Transactions under the Transaction Type of Suspense Transactions detailed in the Contractor's cost proposal in Section C.3.5. Excess suspense transactions shall be determined when the number of suspended claims needing resolution exceeds an average of twelve thousand (12,000) per week for a twelve (12) week period. If the inventory exceeds this total, then the Contractor shall be eligible for reimbursement of excess operations and/or excess staffing that will be needed to facilitate these transactions. The Contractor shall provide sufficient supporting documentation to obtain Bureau approval for reimbursement of the excess transaction costs.

A.6.4.2.1 Provider Customer Service Representative Roles:

a) The Contractor shall perform the following Provider Customer Service activities:

b) Develop procedures for escalation of customer service issues.

c) Establish appropriate Bureau review, approval and sign-off of escalation procedures.

d) Establish preliminary production standards for response which will be adjusted as experience is gained and standards are validated.

e) Identify and hire staff based on ongoing call level projections – one (1) customer service representation for every forty (40) calls per week.

f) Develop training for the CSR staff to include escalation points for each level.

g) Establish facility and infrastructure requirements to accommodate a customer service/provider relations unit.

h) Develop reporting of call escalation and resolution metrics for monthly status reporting to the Bureau.

i) Assist the Bureau with development of a provider manual.

j) Develop training materials for providers for submission of crossover claims.

k) Ensure that calls are responded to and resolved within timeframes established between the Contractor and the Bureau.

l) Serve as a liaison between the Bureau, the Contractor, Tennessee Prison for Women (TPW) and the provider, and facilitate weekly business user meetings to include the Bureau, TPW and the Contractor.

m) Identify and communicate systemic problems to the Contractor's management and the Bureau and assist with resolution.

n) Participate in change management activities to ensure procedures and processes are updated when system or policy changes are implemented.

o) Provide regular reporting of status to Bureau business unit.

A.6.4.2.2 Suspense Processing Role:

a) Suspense resolution activities include the following:

b) Accessing the pending claims file,

c) Selecting the pending claim to be resolved,

d) Reviewing all claim images associated with the pending claim to check for keying errors, and

e) Following the approved procedures for resolving the edits set on the claim record until the claim is in an adjudicated status.

A.6.4.2.3 Finance Role:

a) Process check-related adjustments and or voids

b) Process overpayment/underpayment adjustments

c) Process Financial Change Requests (FCR's)

d) Post Premium Payments

e) Enter Remittance Advice (RA) banner messages into the TCMIS.

A.6.4.2.4 File Maintenance Role:

a) Process Address MCO address changes and Undeliverable address changes.

b) Process MCC Assignment changes

c) Process Patient Liability requests

d) Review samples of recipient identification cards and replacement cards and provide feedback to the vendor

e) Process Medical Eligibility (ME) packets as received and forward materials to designated person(s) within the bureau.

A.6.4.3 Data Capture Services

The Data Capture team shall be staffed as follows:

Role	Number of Staff
Data Capture	21
QA Analyst	1
Data Capture Supervisor	1

A.6.4.3.1 Data Capture Role:

a) Perform, and validate Optical Character Recognition (OCR) and data-entry functions for claims and related inputs for all hard-copy claims and attachments.

b) Provide data capturing on correspondence that is received for indexing

A.6.5 Special Projects

A.6.5.1 Special Project Staffing

Whenever staffing is needed for special projects, a separate payment arrangement shall be made between the Contractor and the Bureau for staffing based on a staffing plan mutually established between the Bureau and the Contractor. Unless otherwise approved by the Bureau, failure to meet the established staffing plan may result in the assessment of liquidated damages in accordance with Attachment B. This compensation method is described in Section C.3.4 of this Contract.

A.6.5.2 Special Project Determination

There shall be new projects that do not fall within normal change requests categories. These are typically large projects such as the recent Reform initiative where the level of effort is significant and the duration is extended. These projects shall not go through the normal change process and shall be staffed and managed through dedicated resources, using the billable rates defined in this Contract.

The Change Control Board (CCB) shall be the avenue to designate a project as a Special Project. Once a project is designated as special, the Contractor shall coordinate with the Bureau to perform an estimate and procure the additional funding approval.

A.6.5.2.1 Special Project Criteria

The criteria for a Special Project are as follows:

a. The requirements of the project are such that they cannot be performed using the existing staff or skill sets, or

b. The duration of the project is extended. The Bureau concludes that if the expected duration of this project is to extend beyond six (6) months, this shall be categorized as a Special Project, or

c. The number of resources is expected to be considerable. The Bureau concludes that if the expected staffing for a change is more than five (5) dedicated resources, then the project shall be considered a Special Project, and

d. The project is of such complexity that a dedicated Project Manager is required.

A.6.5.3 Upcoming Special Projects

The Bureau shall advise the Contractor of any upcoming Special Project initiatives, including but not limited to Vision Integration Platform (VIP).

B. CONTRACT PERIOD

B.1 Contract Term

This Contract shall be effective for the period commencing on 07/01/2009 and ending on 06/30/2013. The State shall have no obligation for services rendered by the Contractor which are not performed within the specified period.

B.2 Term Extension

The State reserves the right to extend this Contract for an additional period or periods of time representing increments of no more than one year and a total contract term of no more than five (5) years, provided that such an extension of the contract term is effected prior to the current, contract expiration date by means of an amendment to the Contract. If the extension of the Contract necessitates additional funding beyond that which was included in the original Contract, the increase in the State's maximum liability will also be effected through an amendment to the Contract, and shall be based upon payment rates provided for in the original Contract.

C. PAYMENT TERMS AND CONDITIONS:

C.1 Maximum Liability

In no event shall the maximum liability of the State under this Contract exceed One hundred seventy million, six hundred sixty two thousand and fifty-four dollars ($170,662,054.00). The payment rates in Section C.3 and the Travel Compensation provided in Section C.4. shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the payment rates detailed in Section C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

C.2 Compensation Firm

The payment rates and the Maximum Liability of the State under this Contract are firm for the duration of the Contract and are not subject to escalation for any reason unless amended.

C.3 Payment Methodology

The Contractor shall be compensated based on the payment rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1.

a) The Contractor’s compensation shall be contingent upon the satisfactory completion of units, milestones, or increments of service defined in Section A.

b) The Contractor shall be compensated for said units, milestones, or increments of service based upon the rates as defined in Section C.3.

c) Pass-Through Cost Payments—The State shall reimburse the Contractor for pass-through costs pre-approved by the State, on the basis of actual cost. Pass-through costs shall not include any overhead, administrative, or other fee or commission. The Contractor shall petition the State for a reimbursement of pass-through costs on a monthly basis, in addition to the regular invoice for professional services provided pursuant to this Contract. The monthly petition for reimbursement of pass-through costs shall include substantiating documentation and the pre-approval by the State. Services reimbursed on a pass-through basis include postal related (i.e., postal services, postage and postal supplies); and third party vendor services (i.e., translation, Edifecs, SunGard, Avaya, and First DataBank). Contractor shall make payment to the Bureau approved postal carrier (the US Postal Service) or the administrator of the Bureau postage meters (the US Postmaster and Pitney Bowes) on behalf of the Bureau; however, the Contractor shall have no responsibility for the delivery by the postal carrier to an addressee. Invoicing for

postage meters shall be based on the funds paid to replenish the meter, less a credit for any Contractor postage in the prior period. Pass-through postage costs do not include Contractor postage for Contractor business operations.

d) Professional Service Payments—The State shall compensate the Contractor based on the Service Rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1.

e) Special Projects Staffing compensation shall be based on the Payment Rates detailed in the Contractor's excess staffing proposal multiplied by the units of service authorized by the Bureau. The Bureau shall compensate the Contractor for Project work based on the hourly rates detailed in the Contractor's excess staffing proposal. The Contractor shall submit monthly invoices, in form and substance agreed to with the Bureau with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall, at a minimum, include the name of each individual, the individual's job title, the number of hours worked during the period, the applicable Payment Rate, the total compensation requested for the individual, and the total amount due the Contractor for the period invoiced.

f) Hardware, Software and Maintenance – The State may request the contractor purchase licenses or maintenance for hardware and software for the TCMIS. The State shall reimburse the Contractor for hardware and software products and maintenance purchased by request of the State based on the actual cost plus an administrative fee in the amount of twenty-one percent (21%) of the actual cost. The Contractor shall petition the State for a reimbursement of maintenance costs on a monthly basis, in addition to the regular invoice for professional services provided pursuant to this Contract, and any and all amendments thereto. The monthly petition for reimbursement of maintenance costs shall include substantiating documentation.

The Contractor shall submit invoices no more often than monthly, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Such invoices shall be submitted for completed project milestones for the amount stipulated.

C.3.1 Assessment Pricing Details

The Contractor shall be compensated "per assessment/deliverable" during the Transition and Implementation Phase of this Contract. The Contractor shall be compensated in accordance with the fixed prices for each assessment/deliverable set forth in this Contract listed in the table labeled "Transition and Implementation Pricing Detail". Total Transition and Implementation Fixed Prices shall factor in all related costs and overhead (e.g., Salaries & Benefits, Travel, Administrative Overhead).

Assessment Pricing Detail Table follows:

Item #	Line Item Description	Fixed Price
1	Assessment 1 – MAR Assessment Section A.2.1.1	$142,881
2	Assessment 2 – ICD-10 Assessment Section A.2.1.2	See Below

ICD-10 Design (further defined in A.2.1.2) reimbursement shall be based on the Payment Rates detailed in C.3.4 Special Projects Staffing for units of service authorized by the State. The Contractor shall submit monthly invoices, in form and substance agreed to with the State with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall, at a minimum, include the name of each individual, the individual's job category, the number of hours worked during the period, the applicable Payment Rate, the total compensation requested for the individual, and the total amount due the Contractor for the period invoiced.

The maximum total fees for ICD-10 Design shall be one million one hundred thousand ninety eight thousand and nine hundred thirty eight dollars ($1,198,938.00). The Bureau may roll any residual funds that are unused for Phase 1 to ICD-10 Remediation (Phase 2) construction, configuration, testing and deployment activities.

C.3.2 Pricing of Major System Enhancements

The Contractor shall be compensated “per enhancement” to complete the TCMIS System Enhancements shown in the Request for Proposals. The Contractor shall be compensated in accordance with the fixed prices for each enhancement set forth in the Contract listed in the table labeled, Pricing of TCMIS System Enhancements. Total Enhancement Fixed Prices will already factor in all related costs and overhead (e.g., Salaries & Benefits, Travel, and Administrative Overhead).

Pricing of TCMIS System Enhancements

Item #	Line Item Description	*Fixed Price
E1	CMMI Level 2 Appraisal (Contract Section A.2.3)	
	Total Enhancement #1	$1,152,723
E1.1	CMMI Level 3 Appraisal (Contract Section A.2.3)	
	Total Enhancement #1.1	$1,353,196
E2	Technology Modernization (Contract Section A.2.4)	
	Total Enhancement #2	$4,681,343
E3	Implement PMO (Contract Section A.2.5)	
	Total Enhancement #3	$1,003,102
E4	Implement a COTS Dashboard (Contract Section A.2.6)	

Item #	Line Item Description	*Fixed Price
	Total Enhancement #4	$553,840
E5	Implement a COTS Documentation software (Contract Section A.2.7)	
	Total Enhancement #5	$2,145,937
E6	Implement Enhanced Test Environment (Contract Section A.2.8)	
	Total Enhancement #6	$2,017,656
E7	Conduct Business Process Improvement (Contract Section A.2.9)	
	Total Enhancement #7	$2,530,716
E8	Implement Long-Term Care CHOICES (Contract Section A.2.10)	
	Total Enhancement #8	See Below

Enhancements #1 and #1.1 monthly invoices shall be in an amount equal to the maximum amount per enhancement detailed above divided by the number of calendar months in the subject period. The Bureau shall require retention of payment in the amount equal to fifteen percent (15%) of each monthly invoice for Enhancements #1 and #1.1. This retention of payment shall be held until the satisfaction of the final deliverable of the certification objective for that enhancement.

Enhancement #2 reimbursement shall be the maximum amount detailed above and allocated to the Bureau's acceptance of the following key deliverables, as follows.

1. Infrastructure Enhancements Installed (A.2.4.4.3 and A.2.4.4.4) = $2,955,125
2. Data Warehouse Enhancements Installed (A.2.4.4.5) = $1,631,763
3. Oracle Financial Transition Plan Accepted (A.2.4.4.6) = $17,870
4. Security Risk Assessment Accepted (A.2.4.4.7) = $ 76,585

Enhancement #3 reimbursement shall be made in lump sum on acceptance by the State of the base PMO standards, structures and staffing.

Enhancements # 4, #5 and #6 shall be made in lump sum upon acceptance by the State and implementation in production.

Enhancement #7 reimbursement shall be in an amount equal to the maximum amount for this enhancement detailed above divided by the number of MITA key business areas targeted by this enhancement, as referenced in A.2.9 and confirmed by the Bureau in the project planning process. Reimbursement for each business area shall be payable upon Bureau acceptance of

the plan for the business processes, including mutually agreed upon process transformations and internal publication of the associated process documentation.

Enhancement #8 reimbursement shall be based on the Payment Rates detailed in C.3.4 Special Projects Staffing for units of service authorized by the State. The Contractor shall submit monthly invoices, in form and substance agreed to with the State with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall, at a minimum, include the name of each individual, the individual's job category, the number of hours worked during the period, the applicable Payment Rate, the total compensation requested for the individual, and the total amount due the Contractor for the period invoiced. The maximum total fees for Long-Term Care (LTC) CHOICES shall be one million nine hundred eighty six thousand two hundred fifty one dollars ($1,986,250.00). The Bureau may roll any residual funds that are unused for LTC CHOICES to ICD-10 Remediation (Phase 2) construction, configuration, testing and deployment activities.

C.3.3 Operations Costs (TCMIS)

Pricing Schedule C1, Item #1 indicates the contracted base rate for operations of the TCMIS, excluding enhancements. Operations compensation shall be based on the Base Rate amounts detailed below for units of service authorized by the State. The Contractor shall submit monthly invoices, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Said monthly invoices shall be in an amount equal to the maximum amount per period detailed below divided by the number of calendar months in the subject period (the divisor shall be twelve (12) after the first period of service).

If, for any reason, the Contractor does not fully meet the operational start date for any of the TCMIS processes and a Contract amendment delaying this date or start-up of a portion of the processing requirements listed has not been approved, then the Contractor shall be liable for costs incurred by the Bureau to continue current operations. Additionally, the Contractor shall forfeit any claims to reimbursement of monthly operations payments for that month and each month thereafter until the Bureau approves operational readiness.

Pricing Schedule C2, Item #1 indicates the contracted incentive rate. The incentive payment shall be paid based on the Contractor receiving a Quality and Customer Service score greater than or equal to eighty-six (86). The Contractor shall receive one hundred percent (100%) of the incentive payment for scores above ninety-three (93). However, the Contractor shall only receive a fifty percent (50%) incentive payment for scores between eighty-six (86) and ninety-three (93).

Pricing schedule C3, Items E1 – E7 shall indicate the contracted rates, if any, for the ongoing operational costs that may be expected for each of the enhancements.

Pricing Schedule C1

Operations Costs – Base Rate (TCMIS)

		Fixed Cost				
Item #	Line Item Description	Operational Year 1 (7/1/2009 – 06/30/2010)	Operational Year 2 (7/1/2010 – 06/30/2011)	Operational Year 3 (7/1/2011 – 06/30/2012)	Operational Year 4 (7/1/2012 – 06/30/2013)	Average
1	Base Rate	$22,270,718	$22,424,491	$23,029,219	$23,662,012	$22,846,610

Pricing Schedule C2

Operations Costs – Incentive Rate (TCMIS)

		Fixed Cost				
Item #	Line Item Description	Operational Year 1 (7/1/2009 – 06/30/2010)	Operational Year 2 (7/1/2010 – 06/30/2011)	Operational Year 3 (7/1/2011 – 06/30/2012)	Operational Year 4 (7/1/2012 – 06/30/2013)	Average
1	Incentive Rate	$3,300,000	$3,300,000	$3,500,000	$3,500,000	$3,400,000

Pricing Schedule C3

Operations Costs – Enhancement Operations (TCMIS)

		Fixed Cost			
Item #	Line Item Description	Operational Year 1 (7/1/2009 – 06/30/2010)	Operational Year 2 (7/1/2010 – 07/30/2011)	Operational Year 3 (7/1/2011 – 06/30/2012)	Operational Year 4 (7/1/2012 – 06/30/2013)
E1	Operations costs associated with maintaining CMMI Level 2 Appraisal	$0	$0	$0	$0
E1.1	Operations costs associated with maintaining CMMI Level 3 Appraisal	$0	$0	$0	$0
E2	Operations costs associated with Technology Modernization		$2,400,000	$2,472,000	$2,546,160
E3	Operations costs associated with PMO	$443,012	$547,563	$563,990	$580,909
E4	Operations costs associated with the COTS Dashboard	$0	$283,660	$292,169	$300,934
E5	Operations costs associated with the COTS Documentation software	$0	$30,258	$31,165	$32,100
E6	Operations costs associated with the Enhanced Test Environment	$21,409	$132,307	$136,276	$140,364
E7	Operations costs associated with Business Process Improvement	$0	$0	$158,190	$162,936
E8	Operations costs associated with LTC CHOICES	$0	$0	$0	$0

C.3.4 Special Projects Staffing

Staffing for Special Projects (further defined in Contract Section A.6) compensation shall be based on the Payment Amounts detailed below for any staffing needs in excess of the contracted staffing levels, as authorized by the Bureau. The State shall compensate the Contractor for Change Order work based on the hourly rates below, in a total amount for each change request not to exceed the written estimate agreed upon by the State and the Contractor. The Contractor shall submit invoices no more often than monthly, in form and substance agreed to with the Bureau with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall be submitted for completed units of service for the amount stipulated. NOTE: The Contractor shall not be compensated for travel time to the primary location of service provision.

CATEGORY	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE
	7/01/2009 - 6/30/2010	7/01/2010 - 6/30/2011	7/01/2011- 6/30/2012	7/01/2012 - 6/30/2013
Information Specialist - Senior	$103.56	$106.67	$109.87	$113.16
Information Specialist	$80.00	$82.40	$84.87	$87.42
Information Analyst	$57.14	$58.85	$60.62	$62.44
Information Associate	$52.08	$53.64	$55.25	$56.91
Business Services Analyst - Senior	$71.56	$73.71	$75.92	$78.20
Business Services Analyst - Advanced	$60.72	$62.54	$64.42	$66.35
Business Services Analyst	$55.00	$56.65	$58.35	$60.10
Technical Delivery Team Manager	$91.93	$94.69	$97.53	$100.45
Project Manager	$95.75	$98.62	$101.58	$104.63
Project Analyst - Senior	$85.00	$87.55	$90.18	$92.88
Project Analyst - Advanced	$75.00	$77.25	$79.57	$81.95
Project Analyst	$65.00	$66.95	$68.96	$71.03
Data Base Administrator	$83.75	$86.26	$88.85	$91.52
Data Base Associate	$68.26	$70.31	$72.42	$74.59
Infrastructure Specialist Senior	$96.53	$99.43	$102.41	$105.48
Systems Administrator - - Advanced	$68.26	$70.31	$72.42	$74.59
Systems Administrator	$56.82	$58.52	$60.28	$62.09
Systems Administrator - Associate	$50.00	$51.50	$53.05	$54.64

CATEGORY	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE
	7/01/2009 - 6/30/2010	7/01/2010 - 6/30/2011	7/01/2011- 6/30/2012	7/01/2012 - 6/30/2013
Computer Operator	$35.00	$36.05	$37.13	$38.25
QA Specialist - Advanced	$70.00	$72.10	$74.26	$76.49
QA Specialist	$55.00	$56.65	$58.35	$60.10
Documentation Project Manager	$70.00	$72.10	$74.26	$76.49
Technical Writer	$45.00	$46.35	$47.74	$49.17
Specialized Support Clerk	$35.00	$36.05	$37.13	$38.25
General Support Clerk	$20.00	$20.60	$21.22	$21.85
Change Management Coordinator	$65.00	$66.95	$68.96	$71.03
Release Coordinator	$65.00	$66.95	$68.96	$71.03
Work Planner	$65.00	$66.95	$68.96	$71.03

C.3.5 Excess Operations Transactions

Excess Operations Transactions compensation shall be based on the Payment Amounts detailed below for any transaction units in excess of the contracted requirement, as authorized by the Bureau. The Contractor shall submit invoices no more often than quarterly in form and substance agreed to with the State with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall be submitted for completed units of service for the amount stipulated.

TRANSACTION TYPE	FIXED FEE PER TRANSACTION			
	07/01/2009 06/30/2010	07/01/2010 – 06/30/2011	07/01/2011 – 06/30/2012	07/01/2012 – 06/30/2013
Suspense Transactions	$0.88	$0.88	$0.89	$0.89

Note:

Excess Suspense Transactions is defined as suspended claims needing resolution activities. Excess suspense transactions shall be determined when the number of suspended claims needing resolution exceeds an average of twelve thousand (12,000) per week for a twelve (12) week period. If the inventory exceeds this total, then the Contractor shall be eligible for reimbursement of excess operations and/or excess staffing that will be needed to facilitate these transactions. The Contractor shall provide sufficient supporting documentation to obtain Bureau approval for reimbursement of the excess transaction costs.

C.4 Travel Compensation

The Contractor shall not be compensated for travel time to the location of service provision. However, the Bureau agrees to reimburse the Contractor for travel expenses relating to Special Projects as defined by the Bureau and necessary to implement changes to the TennCare program regarding enrollment, eligibility, benefits or any other changes required by federal or State law, regulation or policy or by federal or State court order. Special projects compensation to the Contractor for travel, meals, or lodging shall be subject to amounts and limitations specified in the "State Comprehensive Travel Regulations", as they are amended from time to time.

The Contractor shall submit monthly invoices, in form and substance agreed to with the Bureau with reasonable supporting documentation necessary to verify the accuracy of the invoice, prior to any payment. Such invoices shall, at a minimum, include the name of each individual, the date of the expense, the nature of the expense and the total amount due the Contractor for the period invoiced.

C.5 Invoice Requirements

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

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

Bureau of TennCare

310 Great Circle Road

Nashville, TN. 37243

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

(1) Invoice/Reference Number (assigned by the Contractor);

(2) Invoice Date;

(3) Invoice Period (period to which all invoiced charges are applicable);

(4) Contract Number (assigned by the State to this Contract);

(5) Account Name: Department of Finance and Administration, Bureau of TennCare;

(6) Account/Customer Number (uniquely assigned by the Contractor to the above-referenced Account Name);

(7) Contractor Name;

(8) Contractor Federal Employer Identification Number or Social Security Number (as referenced in this Contract);

(9) Contractor Contact (name, phone, and/or fax for the individual to contact with billing questions);

(10) Contractor Remittance Address;

(11) Complete Itemization of Charges, which shall detail the following:

i. Service or Milestone Description (including name /title as applicable) of each service invoiced;

ii. Number of Completed Units, Increments, Hours, or Days as applicable, of each service invoiced;

iii. Applicable Payment Rate (as stipulated in Section C.3.) of each service invoiced;

iv. Amount Due by Service;

v. Travel Compensation requested in accordance with and attaching to the invoice appropriate documentation and receipts as required by the above-referenced "State Comprehensive Travel Regulations"; and

vi. Total Amount Due for the invoice period.

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

(1) include only charges for service described in Contract Section A and in accordance with payment terms and conditions set forth in Contract Section C;

(2) not include any future work but will only be submitted for completed service; and

(3) not include additional sales tax or shipping charges beyond those charged against the Contractor by other vendors.

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

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

C.6 Payment of Invoice

The payment of the invoice by the State shall not prejudice the State's right to object to or question any invoice or matter in relation thereto. Such payment by the State shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any of the amounts invoiced therein.

C.7 Invoice Reductions

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

C.8 Deductions

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

any amounts which are or shall become due and payable to the State of Tennessee by the Contractor.

C.9 Automatic Deposits

The Contractor shall complete and sign an "Authorization Agreement for Automatic Deposit (ACH Credits) Form." This form shall be provided to the Contractor by the State. Once this form has been completed and submitted to the State by the Contractor all payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee shall be made by Automated Clearing House (ACH). The Contractor shall not invoice the State for services until the Contractor has completed this form and submitted it to the State.

D. STANDARD TERMS AND CONDITIONS

D.1 Required Approvals

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

D.2 Modification and Amendment

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

D.3 Termination for Convenience

The State may terminate this Contract without cause for any reason. Said termination shall not be deemed a Breach of Contract by the State. The State shall give the Contractor at least sixty (60) days written notice before the effective termination date. The Contractor shall be entitled to receive compensation for satisfactory, authorized service completed as of the termination date, but in no event shall the State be liable to the Contractor for compensation for any service which has not been rendered. Upon such termination, the Contractor shall have no right to any actual general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

D.4 Termination for Cause

If the Contractor fails to properly perform its obligations under this Contract in a timely or proper manner, or if the Contractor violates any terms of this Contract, the State shall have the right to immediately terminate the Contract and withhold payments in excess of fair compensation for completed services. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any breach of this Contract by the Contractor.

D.5 Subcontracting

The Contractor shall not assign this Contract or enter into a subcontract for any of the services performed under this Contract without obtaining the prior written approval of the State. If such

subcontracts are approved by the State, they shall contain, at a minimum, sections of this Contract below pertaining to "Conflicts of Interest," "Nondiscrimination," and “Records” (as identified by the section headings). Notwithstanding any use of approved subcontractors, the Contractor shall be the prime contractor and shall be responsible for all work performed.

D.6 Conflicts of Interest

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

D.7 Nondiscrimination

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

D.8 Prohibition of Illegal Immigrants

The requirements of Public Acts of 2006, Chapter Number 878, of the state of Tennessee, addressing the use of illegal immigrants in the performance of any Contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.

a. The Contractor hereby attests, certifies, warrants, and assures that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document at Attachment A, hereto, semi-annually during the period of this Contract. Such attestations shall be maintained by the Contractor and made available to state officials upon request.

b. Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the period of this Contract, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Contract. Attestations obtained from such subcontractors shall be maintained by the Contractor and made available to state officials upon request.

c. The Contractor shall maintain records for all personnel used in the performance of this Contract. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.

d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Public Chapter 878 of 2006 for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this Contract.

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

D.9 Records

The Contractor shall maintain documentation for all charges under this Contract. The books, records, and documents of the Contractor, insofar as they relate to work performed or money received under this Contract, shall be maintained for a period of three (3) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.10 Monitoring

The Contractor's activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

D.11 Progress Reports

The Contractor shall submit brief, periodic, progress reports to the State as requested.

D.12 Strict Performance

Failure by any party to this Contract to insist in any one or more cases upon the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any such term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the parties hereto.

D.13 Independent Contractor

The parties hereto, in the performance of this Contract, shall not act as employees, partners, joint venturers, or associates of one another. It is expressly acknowledged by the parties hereto that such parties are independent contracting entities and that nothing in this Contract shall be construed to create an employer/employee relationship or to allow either to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one party shall not be deemed or construed to be

the employees or agents of the other party for any purpose whatsoever.

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

D.14 State Liability

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

D.15 Force Majeure

The obligations of the parties to this Contract are subject to prevention by causes beyond the parties' control that could not be avoided by the exercise of due care including, but not limited to, natural disasters, riots, wars, epidemics, or any other similar cause.

D.16 State and Federal Compliance

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

D.17 Governing Law

This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Contractor agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Contract. The Contractor acknowledges and agrees that any rights or claims against the State of Tennessee or its employees hereunder, and any remedies arising therefrom, shall be subject to and limited to those rights and remedies, if any, available under *Tennessee Code Annotated*, Sections 9-8-101 through 9-8-407.

D.18 Completeness

This Contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.

D.19 Severability

If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this Contract are declared severable.

D.20 Headings

Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

E. SPECIAL TERMS AND CONDITIONS

E.1 Conflicting Terms and Conditions

Should any of these special terms and conditions conflict with any other terms and conditions of this Contract, these special terms and conditions shall control.

E.2 Communications and Contacts

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

The State:

Deputy Commissioner
Department of Finance and Administration
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243
Telephone # (615) 507-6443
FAX # (615) 741-0882
brent.antony@tn.gov

The Contractor:

Account Executive
EDS TennCare
310 Great Circle Road
Nashville, TN 37228
Telephone # (615) 507-6124
dennis.vaughan@eds.com

Copy to:

HP Legal
5400 Legacy Drive
Mail Stop H3-3A-01
Plano, TX 75024
Telephone #(972) 605-5484

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

E.3 Subject to Funds Availability

The Contract is subject to the appropriation and availability of State and/or federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate the Contract upon written notice to the Contractor. Said termination shall not be deemed a breach of Contract by the State. Upon receipt of the written notice, the Contractor shall cease all work associated with the Contract. Should such an event occur, the Contractor shall be entitled to compensation for all satisfactory and authorized services completed as of the termination date. Upon such termination, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E.4 Tennessee Consolidated Retirement System

The Contractor acknowledges and understands that, subject to statutory exceptions contained in *Tennessee Code Annotated*, Section 8-36-801, *et. seq*., the law governing the Tennessee Consolidated Retirement System (TCRS), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established pursuant to *Tennessee Code Annotated*, Title 8, Chapter 35, Part 3 accepts State employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this Contract is that of “employee/employer” and not that of an independent Contractor, the Contractor may be required to repay to TCRS the amount of retirement benefits the Contractor received from TCRS during the period of this Contract.

E.5 Voluntary Buyout Program

The Contractor acknowledges and understands that, for a period of two years beginning August 16, 2008, restrictions are imposed on former state employees who received a State of Tennessee Voluntary Buyout Program (VBP) severance payment with regards to contracts with state agencies that participated in the VBP.

a. The State will not contract with either a former state employee who received a VBP severance payment or an entity in which a former state employee who received a VBP severance payment or the spouse of such an individual holds a controlling financial interest.

b. The State may contract with an entity with which a former state employee who received a VBP severance payment is an employee or an independent contractor. Notwithstanding the foregoing, the Contractor understands and agrees that there may be unique business circumstances under which a return to work by a former state employee who received a VBP severance payment as an employee or an independent contractor of a State contractor would not be appropriate, and in such cases the State may refuse Contractor personnel. Inasmuch, it shall be the responsibility of the State to review Contractor personnel to identify such issues.

c. With reference to either subsection a. or b. above, a contractor may submit a written request for a waiver of the VBP restrictions regarding a former state employee and a contract with

a state agency that participated in the VBP. Any such request must be submitted to the State in the form *VBP Contracting Restriction Waiver Request* format available from the State and the Internet at: www.state.tn.us/finance/rds/ocr/waiver.html. The determination on such a request shall be at the sole discretion of the head of the state agency that is a Party to this Contract, the Commissioner of Finance and Administration, and the Commissioner of Human Resources.

E.6 Breach

A party shall be deemed to have breached the Contract if any of the following occurs:

— failure to perform in accordance with any term or provision of the Contract;
— partial performance of any term or provision of the Contract;
— any act prohibited or restricted by the Contract, or
— violation of any warranty.

For purposes of this Contract, these items shall hereinafter be referred to as a "Breach."

a. Contractor Breach— The State shall notify Contractor in writing of a Breach.

(1) In event of a Breach by Contractor, the State shall have available the remedy of Actual Damages and any other remedy available at law or equity.

(2) Liquidated Damages— In the event of a Breach, the State may assess Liquidated Damages. The State shall notify the Contractor of amounts to be assessed as Liquidated Damages. The parties agree that due to the complicated nature of the Contractor's obligations under this Contract it would be difficult to specifically designate a monetary amount for a Breach by Contractor as said amounts are likely to be uncertain and not easily proven. Contractor hereby represents and covenants it has carefully reviewed the Liquidated Damages contained in Attachment B and agree that said amounts represent a reasonable relationship between the amount and what might reasonably be expected in the event of Breach, and are a reasonable estimate of the damages that would occur from a Breach. It is hereby agreed between the parties that the Liquidated Damages represent solely the damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party. The Contractor agrees that the liquidated damage amount is in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or other section of this Contract.

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

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

In the event the State declares a Partial Default, the State may withhold, together with any other

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

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

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

b. State Breach— In the event of a Breach of Contract by the State, the Contractor shall notify the State in writing within thirty (30) days of any Breach of Contract by the State. Said notice shall contain a description of the Breach. Failure by the Contractor to provide said written notice shall operate as an absolute waiver by the Contractor of the State's Breach. In addition to any other provisions in this Agreement, EDS' nonperformance of its obligations under this Agreement will be excused if and to the extent (a) such EDS nonperformance results from State's failure to perform its responsibilities (or cause them to be performed) and (b) EDS provides State with reasonable notice of such nonperformance and uses commercially reasonable efforts to perform notwithstanding State's failure to perform. In the event of Breach by the State, the Contractor may avail itself of any remedy at law in the forum with appropriate jurisdiction; provided, however, failure by the Contractor to give the State written notice and opportunity to cure as described herein operates as a waiver of the State's Breach. Failure by the Contractor to file a claim before the appropriate forum in Tennessee with jurisdiction to hear such claim within one (1) year of the written notice of Breach shall operate as a waiver of said claim in its entirety. It is agreed by the parties this provision establishes a contractual period of limitations for any claim brought by the Contractor.

E.7 Termination

In the event that the Contractor terminates the Contract, for any reason whatsoever, it will refund to TennCare within ten (10) days of said termination, all payments made hereunder by TennCare to the Contractor for items/work not delivered or not accepted and are not retained by the state. Such termination will require written notice be delivered by the Contractor to the TennCare not less than thirty (30) days prior to said termination.

E.7.1 Termination Under Mutual Agreement

Under mutual agreement, TennCare and the Contractor may terminate this Contract for any reason if it is in the best interest of TennCare and the Contractor. Both parties shall sign a notice of termination which shall include, inter alia, the date of termination, conditions of termination, and extent to which performance of work under this Contract is terminated.

E.7.2 Termination for Cause

Unless otherwise excused under the provisions of this Contract, if the Contractor fails to perform in accordance with any material term or provision of the Contract; only renders partial performance of any material term or provision of the Contract; engages in any act prohibited or restricted by the Contract; or violates any warranty and the Contractor fails to correct such breach with a corrective action plan or other curative measures within a reasonable period of time following written notice, the State shall have the right to immediately terminate the Contract and withhold payments in excess of the contractually provided compensation for completed services and fair compensation for partially completed services that the Bureau has determined to be useful. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any breach of this Contract by the Contractor.

E.7.3 Termination by TennCare for Convenience

TennCare may terminate this Contract for convenience and without cause upon sixty (60) calendar days written notice. If the termination is based upon concerns related to the ownership of the Contractor, the notice period shall be thirty (30) calendar days written notice. Said termination shall not be a Breach of the Contract by TennCare, and except as provided below TennCare shall not be responsible to the Contractor or any other party for any costs, expenses, or damages occasioned by said termination, i.e., without penalty.

The Contractor shall be entitled to receive compensation for satisfactory, authorized service completed as of the termination date and fair compensation for partially completed services that the Bureau has determined to be useful, but in no event shall the State be liable to the Contractor for compensation for any service which has not been rendered. Upon such termination, the Contractor shall have no right to any actual general, special, incidental, consequential, punitive or any other damages whatsoever of any description or amount with the exception of the documented, reasonable costs of an orderly shutdown of account operations, to include severance and turnover activity.

E.7.4 Termination Procedures

The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery. The notice of termination shall specify the provision of this Contract giving the right to terminate, the circumstances giving rise to termination, and the date on which such termination shall become effective.

a. Upon receipt of notice of termination, and subject to the provisions of this Section, on the date and to the extent specified in the notice of termination, the Contractor shall:

b. Stop work under the Contract, but not before the termination date;

c. At the point of termination, assign to TennCare in the manner and extent directed by TennCare all the rights, title and interest of the Contractor for the performance of the subcontracts which were entered into exclusively for the support of the TennCare contract to be determined as needed in which case TennCare shall have the right, in its discretion, to settle or pay any of the claims arising out of the termination of such contract and subcontracts;

d. Complete the performance of such part of the Contract that shall have not been terminated under the notice of termination. If the partial termination is for cause, no notice period is applicable. If the partial termination is for convenience, the same notice period associated with Partial Takeover shall apply. The parties agree to negotiate in good faith the impact to reimbursement under the Contract;

e. Take such action as may be necessary, or as a contracting officer may direct, for the protection of property related to this Contract which is in possession of the Contractor and in which TennCare has or may acquire an interest;

f. Promptly make available to TennCare, or another acting on behalf of TennCare, any and all TennCare records, whether medical, behavioral or financial, related to the Contractor's activities undertaken pursuant to this Agreement. Such records shall be in a usable form and shall be provided at no expense to TennCare;

g. Promptly supply all information necessary to TennCare or another acting on behalf of TennCare for reimbursement of any outstanding claims at the time of termination;

h. Submit a termination plan to TennCare for review, which is subject to TennCare written approval. This plan shall, at a minimum, contain the provisions addressed in the A.3.21 Turnover Tasks. The Contractor shall agree to make revisions to the plan as reasonably necessary in order to obtain approval by TennCare; such approval will not be unreasonably withheld.

i. Agree to comply with all duties and/or obligations incurred prior to the actual termination date of the Contract;

ii. File all reports concerning the Contractor's operations during the term of the Contract in the manner described in this Contract;

iii. In order to ensure that the Contractor fulfills its continuing obligations both before and after termination, maintain the financial requirements (as described in this Contract as of the Contractor's date of termination notice), fidelity bonds and insurance set forth in this Contract until the State provides the Contractor written notice that all continuing obligations of this Contract have been fulfilled.

E.8 Partial Takeover

The State may, at its convenience and without cause, exercise a partial takeover of any service which the Contractor is obligated to perform under this Contract, including, but not limited to, any service which is the subject of a subcontract between Contractor and a third party, although the Contractor is not in Breach (hereinafter referred to as "Partial Takeover"). Said Partial Takeover shall not be deemed a Breach of Contract by the State. Contractor shall be given at least thirty (30) days prior written notice of said Partial Takeover with said notice to specify the area(s) of service the State will assume and the date of said assumption. Any Partial Takeover by the State shall not alter in any way Contractor's other obligations under this Contract. The State may withhold from amounts due the Contractor the amount the Contractor would have been paid to deliver the service as determined by the State. The amounts shall be withheld effective as of the

date the State assumes the service. Upon Partial Takeover, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E.9 State Ownership of Work Products

The State shall have ownership, right, title, and interest, including ownership of copyright, in all work products created, designed, developed, derived, documented, installed, or delivered under this Contract subject to the next subsection and full and final payment for each “Work Product.” The State shall have royalty-free and unlimited rights and license to use, disclose, reproduce, publish, distribute, modify, maintain, or create derivative works from, for any purpose whatsoever, all said Work Products.

a. To the extent that the Contractor uses any of its pre-existing, proprietary or independently developed tools, materials or information ("Contractor Materials"), the Contractor shall retain all right, title and interest in and to such Contractor Materials, and the State shall acquire no right, title or interest in or to such Contractor Materials EXCEPT the Contractor grants to the State an unlimited, non-transferable license to use, copy and distribute internally, solely for the State's internal purposes, any Contractor Materials reasonably associated with any Work Product provided under the Contract.

b. The Contractor shall furnish such information and data as the State may request, including but not limited to computer code, that is applicable, essential, fundamental, or intrinsic to any Work Product and Contractor Materials reasonably associated with any Work Product, in accordance with this Contract and applicable state law.

c. Nothing in this Contract shall prohibit the Contractor's use for its own purposes of the general knowledge, skills, experience, ideas, concepts, know-how, and techniques obtained and used during the course of providing the services requested under this Contract.

d. Nothing in the Contract shall prohibit the Contractor from developing for itself, or for others, materials which are similar to and/or competitive with those that are produced under this Contract.

E.10 Performance Bond

The Contractor shall provide to the State a performance bond guaranteeing full and faithful performance of all undertakings and obligations under this Contract and in the amount equal to ten million dollars ($10,000,000). The Contractor shall submit the bond no later than the day immediately preceding the Contract start date and in the manner and form prescribed by the State (at Attachment E hereto), and the bond shall be issued through a company licensed to issue such a bond in the state of Tennessee. The performance bond shall guarantee full and faithful performance of all undertakings and obligations under this Contract for:

a. the Contract term and all extensions thereof; or

b. the first calendar year of the Contract (ending December 31st following the Contract start date) in the amount of ten million dollars ($10,000,000) and, thereafter, a new performance bond in the amount of ten million dollars ($10,000,000) covering each subsequent calendar year of the contract period. In which case, the Contractor shall provide such performance bonds to the State no later than each December 10th preceding the calendar year period covered beginning on January 1st of each year.

Failure to provide to the State the performance bond(s) as required herein prior to the Contract start date and, as applicable, no later than December 10th preceding each calendar year period covered beginning on January 1st of each year, shall result in contract termination. The Contractor understands that the stated amount of the performance bond required hereunder shall not be reduced during the contract period for any reason.

E.11 Disputes

The Parties agree that any dispute(s) arising out of this Contract that is/are brought forward by Contractor, shall first be addressed by the good faith reasonable efforts of the parties to resolve such dispute(s) through mutual agreement prior to the submission of a claim.

If the above endeavors fail to resolve the dispute(s), any claim by the Contractor against TennCare arising out of the breach of this Contract shall be handled in accordance with the provision of Tennessee Code Annotated § 9-8-301, *et seq*., provided, however, that Contractor agrees that it shall give notice to TennCare of its claim thirty (30) calendar days prior to filing the claim in accordance with Tennessee Code Annotated § 9-8-301, *et seq*. **Notwithstanding the foregoing, TennCare reserves the right, at its sole discretion, to utilize non-binding dispute resolution or mediation services to resolve issues in controversy.**

If the endeavors described in last sentence of the second paragraph of this subsection are attempted and fail to resolve the dispute(s), or should TennCare choose to not exercise its right to first attempt to resolve any dispute(s) by said endeavors, any claim by TennCare against the Contractor shall follow the procedures outlined in Sections D and E relating to Breach and Termination and/or Attachment B, Liquidated Damages.

E.12 Printing Authorization

The Contractor agrees that no publication coming within the jurisdiction of *Tennessee Code Annotated*, Section 12-7-101, *et. seq*., shall be printed unless a printing authorization number has been obtained and affixed as required by *Tennessee Code Annotated*, Section 12-7-103 (d).

E.13 Competitive Procurements

This Contract provides for reimbursement of the cost of goods, materials, supplies, equipment, or contracted services. Such procurements shall be made on a competitive basis, where practical. The Contractor shall maintain documentation for the basis of each procurement for which reimbursement is paid pursuant to the Contract. In each instance where it is determined that use of a competitive procurement method was not practical, said documentation shall include a written justification, approved by the Department of Finance and Administration, Bureau of TennCare, for such decision and non-competitive procurement.

E.14 State Interest in Equipment—Uniform Commercial Code Security Agreement

The Contractor shall take legal title to all equipment and to all motor vehicles, hereinafter referred to as "equipment," purchased totally or in part with funds provided under this Contract, subject to the State's equitable interest therein, to the extent of its *pro rata* share, based upon the State's contribution to the purchase price. "Equipment" shall be defined as an article of nonexpendable,

tangible, personal property having a useful life of more than one (1) year and an acquisition cost which equals or exceeds five thousand dollars ($5,000.00).

As authorized by the provisions of the terms of the Tennessee Uniform Commercial Code—Secured Transaction, found at Title 47, Chapter 9 of the *Tennessee Code Annotated*, and the provisions of the Tennessee Motor Vehicle Title and Registration Law, found at Title 55, Chapter 1 of the *Tennessee Code Annotated*, an intent of this Contract document and the parties hereto is to create and acknowledge a security interest in favor of the State in the equipment or motor vehicles acquired by the Contractor pursuant to the provisions of this Contract document. A further intent of this Contract document is to acknowledge and continue the security interest in favor of the State in the equipment or motor vehicles acquired by the Contractor pursuant to the provisions of this program's prior year Contracts between the State and the Contractor.

The Contractor hereto grants the State a security interest in said equipment. This agreement is intended to be a security agreement pursuant to the Uniform Commercial Code for any of the equipment herein specified which, under applicable law, may be subject to a security interest pursuant to the Uniform Commercial Code, and the Contractor hereby grants the State a security interest in said equipment. The Contractor agrees that the State may file this Contract or a reproduction thereof, in any appropriate office, as a financing statement for any of the equipment herein specified. Any reproduction of this or any other security agreement or financing statement shall be sufficient as a financing statement. In addition, the Contractor agrees to execute and deliver to the State, upon the State's request, any financing statements, as well as extensions, renewals, and amendments thereof, and reproduction of this Contract in such form as the State may require to protect a security interest with respect to said equipment. The Contractor shall pay all costs of filing such financing statements and any extensions, renewals, amendments and releases thereof, and shall pay all reasonable costs and expenses of any record searches for financing statements the State may reasonably require. Without the prior written consent of the State, the Contractor shall not create or suffer to be created pursuant to the Uniform Commercial Code any other security interest in said equipment, including replacements and additions thereto. Upon the Contractor's breach of any covenant or agreement contained in this Contract, including the covenants to pay when due all sums secured by this Contract, the State shall have the remedies of a secured party under the Uniform Commercial Code and, at the State's option, may also invoke the remedies herein provided.

The Contractor agrees to be responsible for the accountability, maintenance, management, and inventory of all property purchased totally or in part with funds provided under this Contract. The Contractor shall maintain a perpetual inventory system for all equipment purchased with funds provided under this Contract and shall submit an inventory control report which must include, at a minimum, the following:

a. Description of the equipment;
b. Manufacturer's serial number or other identification number, when applicable;
c. Consecutive inventory equipment tag identification;
d. Acquisition date, cost, and check number;
e. Percentage of State funds applied to the purchase;
f. Location within the Contractor's operations where the equipment is used;
g. Condition of the property or disposition date if Contractor no longer has possession;
h. Depreciation method, if applicable; and
i. Monthly depreciation amount, if applicable.

The Contractor shall tag equipment with an identification number which is cross referenced to the equipment item on the inventory control report. The Contractor shall inventory equipment annually. The Contractor must compare the results of the inventory with the inventory control report and investigate any differences. The Contractor must then adjust the inventory control report to reflect the results of the physical inventory and subsequent investigation.

The Contractor shall notify the State, in writing, of any equipment loss describing reason(s) for the loss. Should the equipment be destroyed, lost, or stolen, the Contractor shall be responsible to the State for the *pro rata* amount of the residual value at the time of loss based upon the State's original contribution to the purchase price.

The Contractor shall submit its inventory control report of all equipment purchased with the final invoice submitted under this Contract. This inventory control report shall contain, at a minimum, the requirements specified above for inventory control.

Upon termination of the Contract, where a further contractual relationship is not entered into, or at another time during the term of the Contract, the Contractor shall request written approval from the State for any proposed disposition of equipment purchased pursuant to this Contract. All equipment shall be disposed of in such a manner as parties may agree from among alternatives approved by Tennessee Department of General Services and in accordance with any applicable federal laws or regulations.

E.15 State Furnished Property

The Contractor shall be responsible for the correct use, maintenance, and protection of all articles of nonexpendable, tangible, personal property furnished by the State for the Contractor’s temporary use under this Contract. Upon termination of this Contract, all property furnished shall be returned to the State in good order and condition as when received, reasonable use and wear thereof excepted. Should the property be destroyed, lost, or stolen, the Contractor shall be responsible to the State for the residual value of the property at the time of loss.

E.16 Work-papers Subject to Review

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

E.17 Lobbying

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

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

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

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

E.18 Prohibited Advertising

The Contractor shall not refer to this Contract or the Contractor’s relationship with the State hereunder in commercial advertising in such a manner as to state or imply that the Contractor or the Contractor's services are endorsed. It is expressly understood and agreed that the obligations set forth in this section shall survive the termination of this Contract in perpetuity.

E.19 Confidentiality of Records

Strict standards of confidentiality of records shall be maintained in accordance with the State and federal law, regulations and court orders. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of State and federal law and ethical standards and shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with State and federal law and ethical standards.

The Contractor will be deemed to have satisfied its obligations under this section by exercising the same level of care to preserve the confidentiality of the State’s information as the Contractor exercises to protect its own confidential information so long as such standard of care does not violate the applicable provisions of the first paragraph of this section.

The Contractor’s obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the Contractor of this Contract; previously possessed by the Contractor without written obligations to the State to protect it; acquired by the Contractor without written restrictions against disclosure from a third party which, to the Contractor’s knowledge, is free to disclose the information; independently developed by the Contractor without the use of the State’s information; or, disclosed by the State to others without restrictions against disclosure.

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

E.20 Proprietary Ownership of Confidential Records

All records described in Section E.17 of this Contract shall follow the proprietary laws set forth in Titles 10, 24, 33, 47, 56, 63, 68, and 71 of the Tennessee Code Annotated as well as federal law, regulations and court orders.

E.21 Copyrights and Patents

The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims or suits which may be brought against the State for infringement of any laws regarding patents or copyrights which may arise from the Contractor's performance of this Contract. In any such action brought against the State, the Contractor shall satisfy and indemnify the State for the amount of any final judgment for infringement. The Contractor further agrees it shall be liable for the reasonable fees of attorneys for the State in the event such service is necessitated to enforce the terms of this Contract or otherwise enforce the obligations of the Contractor to the State. The State shall give the Contractor written notice of any such claim or suit and full right and opportunity to conduct the Contractor's own defense thereof.

E.22 Public Accountability

If the Contractor is subject to *Tennessee Code Annotated*, Title 8, Chapter 4, Part 4 or if this Contract involves the provision of services to citizens by the Contractor on behalf of the State, the Contractor agrees to establish a system through which recipients of services may present grievances about the operation of the service program, and the Contractor shall display in a prominent place, located near the passageway through which the public enters in order to receive services pursuant to this Contract, a sign at least twelve inches (12") in height and eighteen inches (18") in width stating:

NOTICE: THIS AGENCY IS A RECIPIENT OF TAXPAYER FUNDING. IF YOU OBSERVE AN AGENCY DIRECTOR OR EMPLOYEE ENGAGING IN ANY ACTIVITY WHICH YOU CONSIDER TO BE ILLEGAL, IMPROPER, OR WASTEFUL, PLEASE CALL THE STATE COMPTROLLER'S TOLL-FREE HOTLINE: 1-800-232-5454

E.23 Environmental Tobacco Smoke

Pursuant to the provisions of the federal "Pro-Children Act of 1994" and the Tennessee "Children's Act for Clean Indoor Air of 1995," the Contractor shall prohibit smoking of tobacco products within any indoor premises in which services are provided pursuant to this Contract to individuals under the age of eighteen (18) years. The Contractor shall post "no smoking" signs in appropriate, permanent sites within such premises. This prohibition shall be applicable during all hours, not just the hours in which children are present. Violators of the prohibition may be subject to civil penalties and fines. This prohibition shall apply to and be made part of any subcontract related to this Contract.

E.24 Hold Harmless

The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and

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

In the event of any such suit or claim, the Contractor shall give the State immediate notice thereof and shall provide all assistance required by the State in the State's defense. The State shall give the Contractor written notice of any such claim or suit, and the Contractor shall have full right and obligation to conduct the Contractor's own defense thereof. Nothing contained herein shall be deemed to accord to the Contractor, through its attorney(s), the right to represent the State of Tennessee in any legal matter, such rights being governed by *Tennessee Code Annotated*, Section 8-6-106.

E.25 Debarment and Suspension

The Contractor certifies, to the best of its knowledge and belief, that it, its current and future principals, its current and future subcontractors and their principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or State department or agency;

b. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, State, or local) transaction or grant under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

c. are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, State, or local) with commission of any of the offenses detailed in section b. of this certification; and

d. have not within a three (3) year period preceding this Contract had one (1) or more public transactions (federal, State, or local) terminated for cause or default.

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

E.26 HIPAA Compliance

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

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

b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its

regulations, in the course of performance of the Contract so that both parties will be in compliance with HIPAA.

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

E.27 HITECH Compliance

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

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

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

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

E.28 Tennessee Bureau of Investigation (TBI) Medicaid Fraud and Abuse Unit (MFCU)

TBI/MFCU shall have access to Contractor and Provider Records Office of TennCare Inspector General Access to Contractor, Provider, and Enrollee Records.

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

The Contractor shall immediately report to MFCU all factually based known or suspected fraud, abuse, waste and/or neglect of a provider or Contractor, including, but not limited to, the false or fraudulent filings of claims and/or the acceptance or failure to return money allowed or paid on

claims known to be false or fraudulent. The Contractor shall not investigate or resolve the suspicion, knowledge or action without informing MFCU, and must cooperate fully in any investigation by MFCU or subsequent legal action that may result from such an investigation.

The Contractor and all its health care providers who have access to any administrative, financial, and/or medical records that relate to the delivery of items or services for which TennCare monies are expended, shall, upon request, make them available to MFCU or TennCare OIG. In addition, the MFCU must be allowed access to the place of business and to all TennCare records of any Contractor or health care provider, during normal business hours, except under special circumstances when after hour admission shall be allowed. MFCU shall determine any and all special circumstances.

The Contractor and its participating and non-participating providers shall report TennCare enrollee fraud and abuse to TennCare OIG. The Contractor and/or provider may be asked to help and assist in investigations by providing requested information and access to records. Shall the need arise, TennCare OIG must be allowed access to the place of business and to all TennCare records of any TennCare Contractor or health care provider, whether participating or non-participating, during normal business hours.

The Contractor shall inform its participating and non-participating providers that as a condition of receiving any amount of TennCare payment, the provider must comply with this Section of this Contract regarding fraud, abuse, waste and neglect.

This provision applies to the provider healthcare contracts held by the Contractor, if any.

E.28.1 Prevention/Detection of Provider Fraud and Abuse

The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities.

E.28.2 Fraud and Abuse Compliance Plan

The Contractor shall have a written Fraud and Abuse compliance plan and initiate appropriate internal controls. A paper and electronic copy of the plan shall be provided to the State Office of the Inspector General. The Contractor's specific internal controls and polices and procedures shall be described in a comprehensive written plan and be maintained on file with the Contractor for review and approval by the State Office of the Inspector General by the Modified Operation Start Date of this Agreement. The State Office of the Inspector General shall provide notice of approval, denial, or modification to the Contractor within thirty (30) days of review. The Contractor shall make any requested updates or modifications available for review to TennCare and/or the State Office of the Inspector General as requested by TennCare and/or the State Office of the Inspector General within thirty (30) days of a request. The State shall not transfer their law enforcement functions to the Contractor. At a minimum the written plan shall:

i. Ensure that all managers and employees know and understand the provisions of the Contractor's fraud and abuse compliance plan;

ii. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract:

iii. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and fraud, such as Claims edits;

iv. Contain provisions for the confidential reporting of suspect plan violations to the designated person as described in item E.28.3 below;

v. Contain provisions for the investigation and follow-up of any compliance plan reports;

vi. Ensure that the identities of individuals reporting violations of the plan are protected;

viii. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU (Medicaid Fraud Control Unit) and that enrollee fraud and abuse be reported to the State Office of the Inspector General;

ix. Ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.

E.28.3 Fraud and Abuse Compliance Officer

The Contractor shall designate an owner in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.

E.28.4 Annual Report to OIG

The Contractor shall submit an annual report to the State Office of the Inspector General that includes summary results of fraud and abuse tests performed as required by E.28.2.iii and detailed in the Contractor's Fraud and Abuse compliance plan. The report should cover results for the year ending June 30 and be submitted by September 30 each year. This information in this report shall be provided in accordance with and in a format as described in the Contractor's approved compliance plan.

E.29 Failure to Meet Agreement Requirements

It is acknowledged by TennCare and the Contractor that in the event of failure to meet the requirements provided in this Contract and all documents incorporated herein, TennCare will be harmed. The actual damages that TennCare will sustain in the event of and by reason of such failure are uncertain, are extremely difficult and impractical to ascertain and determine. The parties therefore acknowledge that the Contractor shall be subject to damages and/or sanctions as described in Attachment B of this Contract. It is further agreed that the Contractor shall pay TennCare liquidated damages as directed by TennCare and not to exceed the fixed amount as stated in Attachment B of this Contract and identified in Attachment A of the *pro forma* contract; provided however, that if it is finally determined that the Contractor would have been able to meet the Contract requirements listed in Section A of this Contract but for TennCare's failure to perform as provided in this Contract, the Contractor shall not be liable for damages resulting directly therefrom.

E.30 Offer of Gratuities

By signing this Contract, the Contractor signifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the General Accounting Office, Department of Health and Human Services, CMS, or any other federal agency

has or will benefit financially or materially from this procurement. This Contract may be terminated by TennCare if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, his agent, or employees and may result in termination of the Contract as provided in Section D.

E.31 Limitation of Liability

The parties agree that the total liability of the Contractor for breach of this Contract shall not exceed two (2) times the value of this contract. The value shall be established by the Contract Maximum Liability in Section C.1 and increased by subsequent amendments, if any. The foregoing provision shall not limit the contractor's liability for intentional torts, criminal acts or fraudulent conduct. In no event will the measure of damages payable by either Party include, nor will either Party be liable for, any amounts for loss of income, profit or savings or indirect, incidental, consequential, exemplary, punitive or special damages of any party, including third parties, even if such Party has been advised of the possibility of such damages in advance, and all such damages are expressly disclaimed.

E.32 Exigency

E.32.1 State Option to Extend for Public Exigency

At the option of the State, the Contractor agrees to continue services under this Contract when TennCare determines that there is a public exigency that requires the services to continue. Continuation of services pursuant to this Section shall be in three (3) month increments and the total of all public exigency extensions shall not exceed twelve (12) months. Thirty (30) calendar days written notice shall be given by TennCare before this option is exercised.

E.32.2 Exigency Extension Amends Contract

A written notice of exigency extension shall constitute an amendment to the Contract, may include a revision of the maximum liability and other adjustments permitted under Section C, and shall be approved by the Commissioner of Finance and Administration and the Office of the Comptroller of the Treasury.

E.32.3 Continuing Payments During Exigency

During any periods of public exigency, TennCare shall continue to make payments to the Contractor as specified in Section C of this Contract.

E.33 Records/Discovery

In addition to the records audits referenced other sections of this Contract, the Contractor shall make available all records of whatever media (correspondence, memoranda, databases, worksheets, training material, etc.), in their original form, be it electronic or paper, including emails with metadata preserved. These records shall be produced to TennCare at no cost to the State, as required to satisfy evidence discovery demands of any of litigation, including state or federal class action, affecting TennCare. The State shall endeavor to keep the evidence discovery requests as limited as reasonably possible. The Contractor shall retain the right to object in court to any evidence discovery requests it may feel is too broad or otherwise unduly burdensome.

E.34 Supplemental Force Majeure

In addition to the language contained in D.15 Force Majeure, the obligations of the parties to this Contract are subject to the following prevention by causes beyond the parties' control: court orders, acts or regulation of government bodies, or any other similar cause.

IN WITNESS WHEREOF,

ELECTRONIC DATA SYSTEMS, L.L.C.

GRANTEE SIGNATURE — DATE 6/22/09

Barbara Anderson, Vice President, State & Local Health and Human Services

PRINTED NAME AND TITLE OF GRANTEE SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION

BUREAU OF TENNCARE:

M.D. GOETZ, JR., COMMISSIONER — DATE 6/24/09

APPROVED:

M. D. GOETZ, JR., COMMISSIONER
DEPARTMENT OF FINANCE AND ADMINISTRATION — DATE 7/12/09

JUSTIN P. WILSON, COMPTROLLER OF THE TREASURY — DATE 7/28/09

Attachment A Attestation Regarding Personnel

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	Electronic Data Systems, L.L.C.
FEDERAL EMPLOYER IDENTIFICATION NUMBER (or Social Security Number):	75-2714842

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

CONTRACTOR SIGNATURE _____

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. If said individual is not the chief executive or president, this document shall attach evidence showing the individual's authority to contractually bind the Contractor.

PRINTED NAME AND TITLE OF SIGNATORY Barbara Anderson, Vice President, State & Local Health and Human Services, EDS

DATE OF ATTESTATION _____

Attachment B Incentives and Liquidated Damages

Contractor Incentives and Liquidated Damages

B.1 Contractor Incentive - Performance-Based Contract and Damages

To effectively manage contractual performance, the Bureau has established measures to evaluate the Contractor's obligations with respect to the requirements. The Contractor is expected to perform according to a certain level of standards. If these standards are not met, the State is entitled to impose damage assessment stratagems and institute dispute resolutions. If the Contractor surpasses performance standards they may be entitled to an incentive payment, as documented in the Performance Reporting System. These measures are meant to support all activities required to operate and enhance the TCMIS infrastructure.

B.1.1 Contractor Incentive - Performance Management and Measures

The Contractor shall be measured in all of the business functional areas for quality system and operational performance, based upon criteria developed by the Bureau.

These criteria shall:

Improve the quality of Contractor performance;

Provide documented performance levels in all critical areas of the system;

Improve the management of the Contractor's Contract; and

Improve the State and federal government return on investment for administration of the TennCare program.

The Bureau shall identify areas of Contractor performance where quality is critical to the mission of the TennCare Program.

During Transition, the Bureau shall reach agreement with the Contractor concerning the critical areas of performance, performance standards, and levels of quality that are desirable, acceptable and substandard. These standards shall be documented in a Performance Reporting plan, which shall be incorporated into the Performance Reporting System. The evaluation of performance shall occur quarterly, beginning during the first State Fiscal quarter after the Performance Reporting System is operational. The agreement concerning critical areas of performance, performance standards, and levels of quality, between the Contractor and the Bureau, shall be reached ninety (90) days prior to the Modified Operations Start Date. If an agreement is not reached during this time, the incentives shall not take effect on the start of operations. Additionally, the annual incentive shall be decreased by one-fourth (1/4) for any quarter when the incentive is not effective at the beginning of the quarter. The effective date of the incentive shall be the later of the start of operations or ninety (90) days after the agreement between the Bureau and the Contractor concerning critical areas of performance, performance standards, and levels of quality. The agreement shall be memorialized in an official correspondence that shall be filed with the Department of Finance and Administration, Office of Contract Review, and with the Comptroller of the Treasury.

The Contractor shall develop and/or install a Performance Reporting System as a means to measure quality levels on a monthly basis.

The Bureau shall establish a range for Contractor performance for high quality, acceptable quality, and performance that shall require corrective action on the part of the Contractor.

During the course of the Contract, performance standards shall be measured by the Bureau, using the Performance Reporting System.

Bureau Contract Management shall actively participate with the Contractor in using the Performance Reporting System and shall approve the results recorded.

B.1.2 Approach to Performance Standards and Damages

B.1.2.1.The Bureau shall identify areas of Contractor performance where quality is critical to the mission of the TennCare Program.

B.1.2.2. During Start-up, the Bureau shall reach agreement with the Contractor concerning the critical areas of performance, performance standards, and levels of quality that are desirable, acceptable and substandard for each area, as outlined in B.1.1.

B.1.2.3. The Contractor shall provide an automated method for TCMIS and other system/operations tools used to provide the monthly reports of the quality measurements agreed upon by the Bureau and the Contractor at no additional programming cost to the Bureau.

B.1.2.4. The automated reports shall be flexible and adaptable to changes in the quality measurements as agreed upon by the Bureau and Contractor through a rules-based engine, or component of a rules-based engine, in the TCMIS. At no time during the performance of this Contract shall Liquidated Damages be assessed against Contractor for failure to deliver a report, log or other compliance indicator before these tools have been created and approved by the Bureau.

B.1.2.5. During the term of the Contract, the Contractor shall measure performance using the Performance Reporting System. Bureau Contract Management staff shall actively participate with the Contractor in the performance reporting process and shall approve the results recorded.

B.1.2.6. Critical areas of performance, performance standards, levels of quality, and the associated measurements shall be reviewed by the Bureau and the Contractor on a quarterly basis to assess any critical areas of performance, performance standards, levels of quality, or any associated measurements that should be changed, added or deleted for the next reporting period. The review of the critical areas of performance, performance standards, levels of quality and associated measurements shall be completed and agreed upon at least forty-five (45) days prior to the beginning of the subsequent quarter. If an agreement is not reached at least forty-five (45) days prior to the beginning of the subsequent quarter, the incentive shall not be effective the subsequent quarter. Additionally, the annual incentive shall be decreased by one-fourth (1/4) for any quarter when the incentive is not effective at the beginning of the quarter. These agreements will be incorporated into the Performance Reporting Plan. The agreement shall be memorialized in an official correspondence that shall be filed with the Department of Finance and Administration, Office of Contract Review, and with the Comptroller of the Treasury.

B.1.2.7. At the end of each reporting period, the Performance Reporting System results shall be posted on the TennCare intranet.

B.1.2.8. An independent, accredited auditing firm shall review the flow of information used in the Performance Reporting System on an annual basis as part of the annual SAS-70 review.

B.1.2.9. Each performance measure shall have its own scoring mechanism established through negotiation with the Contractor and the Bureau and shall consist of scoring elements totaling one hundred (100) points. For each of the performance measures, the number of points scored shall determine a quality score, as follows:

94 to 100 points	=	Significantly Exceeds Contract Requirement
86 to 93 points	=	Exceeds Contract Requirement
78 to 85 points	=	Meets Contract Requirement
70 to 77 points	=	Partially Meets Contract Requirement
Below 70 points	=	Does Not Meet Contract Requirement

A corrective action shall be required for performance measures that score seventy-seven (77) or below.

Liquidated and actual damages may be assessed for performance measures that are not resolved based on the Contractor's corrective action plan.

B.1.3 Right to Assess Damages

The Bureau may assess damages based on evaluations of the Contractor's success in meeting required performance standards by the Bureau Contract Administrator. The Contractor may accept the damages assessed by the Bureau or challenge the reimbursement to the Bureau for actual damages or the amounts set forth as liquidated damages.

If the Contractor disagrees with the damage assessment, the following resolution steps shall be followed:

1) Contractor management may first discuss the issues verbally with Bureau management.

2) Contractor management may submit a written document to propose a corrective action plan to remedy the deficiency. The Bureau reserves the right in its sole discretion to grant the Contractor the opportunity to cure deficient performance by means of a Corrective Action Plan (CAP). Contractor's failure to meet the terms of the CAP may result in the assessment of damages.

3) The Bureau may elect to present the issue to the Director of TennCare and ask that s/he meet with Contractor management for issues resolution or damage assessment.

4) If damages can be measured in actual cost, they shall be referred to as actual damages. If the damages are difficult to measure or cannot be measured in actual cost, they shall be referred to as liquidated damages.

5) The Bureau shall notify the Contractor in writing of the proposed damage assessment. The amounts due the Bureau as actual damages may be deducted from any fees or other compensation payable to the Contractor, or the Bureau may require the Contractor to remit the damages within thirty (30) days following the notice of assessment or resolution of any dispute. At the Bureau's option, the Bureau may obtain payment of assessed actual damages through one (1) or more claims upon any performance bond furnished by the Contractor.

B.1.4 Actual and Liquidated Damages

Damage may be sustained by the Bureau in the event that the Contractor fails to meet the requirements of this Contract. In the event of default or the inability to maintain minimum requirements or standards as determined by the Bureau, the Contractor agrees to pay the Bureau for the actual cost of damages or the specifically outlined sums as liquidated damages. The maximum amount of Liquidated Damages payable over any twelve (12) month period shall not exceed 20 percent of the annual fixed price billings. In the event that a single occurrence subjects the Contractor to Liquidated Damages in multiple subsections of this provision, the State is entitled to assess a single Liquidated Damage selected as the discretion of the State. Liquidated Damages shall not be assessed if the delay or failure to timely perform its obligations is caused by factors beyond the reasonable control and without any material error or negligence of the Contractor, its staff or subcontractors. Liquidated damages are considered compensation for increased Contract management and do not constitute a penalty.

The list of Liquidated Damages and Performance Metrics are included in this Attachment.

B.1.5 Dispute Resolution Process for Damage Assessments

The Bureau expects that any disputes arising under this Contract shall be approached first through negotiations with the Bureau's Contract Manager and second through negotiation with the Deputy Commissioner of Finance and Administration, Bureau of TennCare. Legal action should only be initiated if all of these mechanisms fail.

Notwithstanding the foregoing, TennCare reserves the right, at its sole discretion, to utilize non-binding dispute resolution or mediation services to resolve issues in controversy.

Regardless of whether or not informal negotiation, non-binding mediation or legal action is used to resolve the dispute, the State may make a claim against the Performance Bond required under this contract after a third party has given an opinion on the merits of the dispute, either through mediation or a court proceeding, or after two years, whichever comes first. See Section E.11.

Venue for any disputes shall be in Nashville, Tennessee. In any such review, the Contractor shall have the burden to prove the decision of the Bureau's Contract Manager to be incorrect. Pending final determination of any dispute, the Contractor shall proceed diligently with performance of the Contract and in accordance with the direction of the Bureau's Contract Manager.

B.2 Actual Damages

Amounts due the Bureau as actual damages may be deducted by the Bureau from any money payable to the Contractor pursuant to this Contract. The Bureau shall notify the Contractor in writing on or before the date the Bureau deducts such sums from money payable to the Contractor. Actual damages are assessed only for errors due to omissions or negligence of the Contractor.

Contractor shall be responsible for timeliness of Claims Processing, such that the aggregate fee-for-service claims timeliness are within the prompt pay standards set by CMS. For aggregate fee-for-service claims the standards are:

1) Ninety Percent (90%) of all clean claims shall be paid or denied within thirty (30) days of receipt; and

2) Ninety-nine Percent (99%) of all clean claims shall be paid or denied within ninety (90) days of receipt.

The damage that may be assessed shall be the resulting loss in federal match for the payments processed by the Contractor. Contractor shall not be liable to the extent the non-compliance with Prompt Pay is caused by the Bureau or another fee-for-service processing designee of the Bureau.

Contractor shall be liable for the actual amount of claims overpayments caused by Contractor, that are not recovered by the Bureau within sixty (60) days using available remedies for recoupment or recovery, unless the Bureau has written-off the provider receivable. Contractor may pursue recovery of the overpayment from the provider through the TCMIS accounts receivable process.

The Contractor shall ensure it meets all federal laws and regulations with regard to privacy, security, and individually identifiable health information pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended and the Health Information Technology for Economic and Clinical Health Act (HITECH) under the American Recovery and Reinvestment Act of 2009 (ARRA), and as specified in the Facilities Management General Operations Section A.3.20.

The Contractor shall deliver, maintain and operate the TCMIS in full compliance with the HIPAA and HITECH. EDI requirements can be found in Section A.3.19.

The Contractor shall be responsible for HIPAA compliance of the TCMIS regardless of its status as a covered entity or business associate of the Bureau.

The actual damages for the Contractor’s failure to comply with HIPAA and HITECH shall be any and all costs associated with the reporting, mitigation, remediation and any and all other federal or state law requirements including, but not limited to, civil money penalties assessed against the Bureau.

B.3 Liquidated Damages

B.3.1 Damage Provisions

All requirements described in this Contract are subject to monitoring by the Bureau of TennCare. The Contractor shall track and comply with all performance measures, commitments and requirements. Upon the completion of the Dashboard Enhancement, the parties shall agree upon the reports and performance measures that will be included in the compliance dashboard to track completion of Contractor commitments. The Bureau reserves the right to monitor performance at any time and may exercise such option, at its discretion, without notice. In the event of a failure to meet the performance requirements, the Contractor agrees that the Bureau of TennCare may assess and withhold from payments due its liquidated damages set forth below and as assessed at the Bureau's discretion. If not specifically designated, liquidated damages, if any, shall be assessed on a monthly basis. The Bureau has sixty (60) days to issue a claim for Liquidated Damages, from the end of the month in which the deficiency is discovered.

Payment of Liquidated Damages

It is further agreed by Bureau and the Contractor that any liquidated damages assessed by Bureau shall be due and payable to Bureau within thirty (30) calendar days after Contractor receipt of the notice of damages. If payment is not made by the due date, said liquidated damages may be withheld from future payments by Bureau without further notice. It is agreed by Bureau and the Contractor that the collection of liquidated damages by Bureau shall be made without regard to any appeal rights the Contractor may have pursuant to this Contract; however, in the event an appeal by the Contractor results in a decision in favor of the Contractor, any such funds withheld by Bureau shall be immediately returned to the Contractor.

Deduction of Damages from Payments

Amounts due the Bureau as liquidated damages may be deducted by the Bureau from any money payable to the Contractor pursuant to this Contract. The Bureau shall notify the Contractor in writing of any claim for liquidated damages at least thirty (30) calendar days prior to the date the Bureau deducts such sums from money payable to the Contractor. Such amounts as they relate to Section C.3 of the Contract may be deducted during the entire period that MMIS certification is lacking. Should certification subsequently be granted retroactively, the Bureau shall reimburse the Contractor for any amounts that have been withheld due to lack of certification.

Waiver of Liquidated Damages

Bureau may waive the application of liquidated damages and/or withholds upon the Contractor if the Contractor is placed in rehabilitation or under administrative supervision if Bureau determines that such waiver is in the best interests of the TennCare program and its enrollees.

The Bureau may also waive the assessment of Liquidated Damages at its sole discretion, for any failure of performance by the Contractor.

To facilitate the compliance process with respect to Liquidated Damages, the parties agree that the Bureau Program Director or their designee. All letters notifying the Contractor of the potential assessment of Liquidated Damages or letters actually assessing Liquidated Damages will be sent by this Bureau representative.

The Liquidated Damages will be managed by the Control Memorandum(a) process as contained in A.1.2.4 of the contract. Failure to complete or comply with an ORR may result in the assessment of liquidated damages in the amount of one hundred dollars ($100.00) per business day starting on the business day after the ORR due date. All due dates requested during this process shall be reasonable and shall not include weekends or holidays. Failure to complete or comply with a Control Directive deliverable may result in the assessment of liquidated damages in the amount of five hundred dollars ($500.00) per business day starting on the calendar day after the deliverable due date. This damage assessment shall not include weekends and holidays.

B.3.2 Liquidated Damage - Failure to Meet Contractor Performance Requirements

It is agreed by the Bureau and the Contractor that, in the event of a failure to meet the performance requirements listed in the following sections, damage is deemed to have been sustained by the Bureau. It is further agreed that it is and will be impractical and extremely difficult to ascertain and determine the actual damage that the Bureau has sustained or will sustain in the event of, and by reason of, such failure. It is therefore agreed that the Contractor shall pay the Bureau for such failures at the sole discretion of the Bureau according to the following business areas and subsections.

Damage assessments are linked to performance of operational responsibilities. Where an assessment is defined as an "up to (amount)," the dollar value per occurrence may be set at the discretion of the Bureau of TennCare, up to the amount specified.

For those requirements subject to a corrective action plan, written notification of each failure to meet a performance requirement shall be given to the Contractor by the Contract Administrator or his/her designee. The Contractor shall comply with the requirements of the approved corrective action plan. Liquidated Damages, if assessed, shall start to accrue on the first business day after the deliverable is not met The imposition of liquidated damage is not in lieu of any other remedy available to the Bureau.

General Liquidated Damages - In the event that the Contractor has failed to meet a performance requirement that is set out in the Contract, but for which the Liquidated Damages standards are not spelled out in this Attachment, the Bureau may assess Liquidated damages under this General Liquidated Damages provision. The Liquidated Damages will be assessed at the rate of five hundred dollars ($500.00) per business day until the requirement has been met.

Liquidated damages may not be assessed against the Contractor in those instances where the Bureau determines that inconsequential damage has occurred.

B.3.2.1 Deliverables

For any Deliverable not completed and submitted to, and accepted by the Bureau by the expected completion date, payment directly associated with that deliverable shall not be made to the Contractor. In addition, Liquidated Damages may be assessed by the Bureau.

B.3.2.2 Sanctions by CMS – Consequential Damages

If CMS imposes fiscal sanctions against the Bureau as a result of the Contractor's or any subcontractor's wrongful action or inaction, the Contractor shall compensate the Bureau the amount lost by the Bureau by application of the sanctions.

B.3.2.3 Enhancements

Failure to develop and implement any of the Enhancements to the TCMIS by the approved Work Plan delivery date, or if any of these Enhancements negatively impact the operations of the TCMIS, then no payment shall be made to the Contractor for that Enhancement until resolution and damages may be assessed by the Bureau.

B.3.2.4 Recovery

If, in the reasonable judgment of the Bureau, a default by the Contractor is not so substantial as to require termination and reasonable efforts to induce the Contractor to cure the default are unavailing, and the default is capable of being cured by the Bureau or by another resource without unduly interfering with continued performance by the Contractor, the Bureau may provide or procure the services reasonably necessary to cure the default. In which event the Contractor shall reimburse the Bureau for the reasonable cost of the services. In addition, the Contractor shall cooperate with these resources in allowing access to the computer facility, documentation, software, utilities, and equipment. The Contractor shall remain liable for all system performance criteria, maintenance of and further enhancements to any applications developed by these resources to the extent that it constitutes the Contractor's work product whether impacted by the work of the other resource or not.

B.3.2.5 Performance Reporting System Evaluation

Requirements:

The Contractor shall be required to meet the requirements of this Contract in all areas measured by the Performance Reporting System.

The liquidated damages for performance measure areas that score below seventy-seven (77) shall be five thousand dollars ($5,000) for each deficient area.

The liquidated damages for performance measure areas that score below seventy (70) shall be ten thousand dollars ($10,000) for each deficient area.

B.3.2.6 Milestones or Phases

Requirements:

Unless otherwise specified, key milestones and phases that occur during the Planning, Design, Development, Testing, and Implementation Phases associated with Special Projects and Enhancements shall be completed by the Contractor in final form on the dates specified in the approved Work Plan. The Bureau shall review and provide written acceptance of all key milestones or phases.

The liquidated damages shall be one thousand dollars ($1,000) per workday for each day the key milestone or phase is late or unacceptable.

B.3.2.7 Sponsorship

Requirements:

Any publicity given to the program or services, including, but not limited to: notices, information pamphlets, press releases, research, reports, signs, and similar public notices prepared by or for the Contractor shall be pre-approved by the Bureau prior to release.

The liquidated damages shall be five thousand dollars ($5,000) per incident in which the Bureau approval is not obtained.

B.3.2.8 Performance Reporting System Report-Timeliness

Requirements:

The Contractor shall provide a monthly performance report produced by the Performance Reporting System in a manner acceptable to the Bureau, within fourteen (14) workdays of the end of the month.

The liquidated damages for failure to provide the report timely or in a manner acceptable to the Bureau shall be five hundred dollars ($500) a day for each workday the report is not received or acceptable.

B.3.2.9 Key Staff Thresholds

Requirement:

The Contractor shall be required to meet the minimum staffing level requirements of the Contract for the Key Staff positions as listed in Section A.6.2.

Liquidated Damage Assessment:

If the Contractor fails to comply with the thirty (30) calendar day notice requirement, where possible, the liquidated damage assessment shall be five-hundred dollars ($500) per business day until a resume for a qualified candidate is submitted and such candidate is reasonably available.

If the Contractor fails to comply with the submission of a resume of an appropriately qualified individual within sixty days, the Liquidated Damage assessment shall be $500 per business day.

B.3.2.10 Other Staff Thresholds

Requirement:

The Contractor shall be required to meet the minimum staffing level requirements of the Contract for Maintenance and Modifications Staff, as listed in Section A.6.3 and Operations Processing Staff, as listed in Section A.6.4.

Liquidated Damage Assessment:

If the Contractor fails to comply with these staffing level requirements for a given month, the Liquidated Damage assessment shall be $4,000.00 per Maintenance and Modification person below the allowable threshold and $1,000.00 per Operations Processing staff below the allowable threshold.

If the Contractor fails to comply with the on-site or dedicated staffing level requirements, the Liquidated Damage assessment shall be $500 for that month.

B.3.3 Liquidated Damages: Failure to meet Contractor Commitments

The Contractor shall, at all times, operate the TCMIS and its activities in conformity with the policies and procedures of the Bureau. The Bureau and Contractor agree that any delay or failure by Contractor to timely perform its obligations by the dates in the approved Work Plan and in accordance with the Performance Commitments will interfere with the proper and timely operations of the System and Facilities Manager services, to the loss and damage of the Bureau. Further, the Bureau will incur costs to maintain the functions that would have otherwise been performed by Contractor. The Bureau and the Contractor understand and agree that this Section describes the liquidated damages the Contractor shall pay to the Bureau at the Bureau's discretion as a result of nonperformance hereunder by the Contractor.

All requirements described in this Contract are subject to monitoring by the Bureau. The Bureau reserves the right to monitor performance at any time and may exercise such option, at its discretion, without notice. The assessment of penalties shall not constitute a waiver or release of any other remedy the Bureau may have under this Contract for the Contractor's breach of this Contract, including without limitation, the Bureau's right to terminate this Contract. The Bureau shall be entitled in its discretion to recover actual damages caused by the Contractor's failure to perform its obligations under this Contract.

If the system-related Enhancements fail to meet performance commitments due to the unexcused failure on the part of the Contractor during the year following their implementation and while the Contractor is providing Facilities Management services, the Contractor shall modify, reconfigure, upgrade or replace software and equipment at no additional cost to the Bureau in order to provide a system solution that complies with such performance standards. Contractor is not liable for upgrades or performance of State-owned third party licensed software or hardware.

The Bureau confirms that the amounts stated for each occurrence of each performance failure defines the maximum compensation due from the Contractor and that the amount claimed shall be adjusted downward to eliminate any proportion of the cost caused by the Bureau's failure to meet its contractual responsibility, or for any other reasonable cause at the discretion of the Bureau. Liquidated Damages, if assessed, shall start to accrue on the first business day after the deliverable was not met.

B.3.3.1 MMIS Certification

The TCMIS System, and all of its subsystems and components, shall meet federal certification requirements defined in the most current version of Part 11 of the State Medicaid Manual. It is imperative that the enhanced TCMIS be complete, stable, fully operational, and of the highest quality. Federal authorities may elect to review the TCMIS and re-certify that the system operations continue to meet Federal MMIS standards. The Bureau shall notify the Contractor if such review is requested. The following subsection listed below describes the Certification-

related activities. This list may not be all inclusive; it is the responsibility of the Contractor to ensure that all Certification activities contained within the Contract and Part 11 of the State Medicaid Manual meet the requirements.

Reference or Contract section – Listed below: A.5.2 MMIS Certification

The following table lists the operational responsibilities and performance expectations that the Bureau has for MMIS Certification and related activities.

MMIS Certification Table

MMIS Certification Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
Contractor shall demonstrate that TCMIS processes meet Certification requirements (system reports, file updates, documentation updates).	If CMS does not grant System Certification as scheduled in the Enhancements Work Plan, the Bureau may assess Liquidated Damages from the start of operations date and until CMS certification is achieved and CMS notification of decision is received in writing.	Retroactive to the beginning of the certification review period.	The Bureau may assess any FFP damages which is the difference between the maximum allowable FFP from what was actually received by the Bureau over the same time period. These damages may be retroactive from the start of operations if so found by CMS. Additionally, the Bureau may assess one thousand dollars ($1,000) per calendar day from the start of operations date and until CMS certification is achieved and CMS notification	

MMIS Certification Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
			of their decision is received in writing.	
Contractor shall comply with CMS Certification requirements as the TCMIS is maintained.	CMS fails to approve certification, and withholds FFP for any month, or portion thereof.	Retroactive to the beginning of the certification review period.	The damage that may be assessed shall be whatever damages or penalties CMS assesses.	

B.3.3.2 Change Management

It shall be the responsibility of the Contractor to ensure all Change Management activities contained within the Contract meet the requirements. This list may not be all inclusive; it is the responsibility of the Contractor to ensure all Change Management activities contained within this Contract meet the requirements.

Reference or Contract section – Listed below:

A.1.2 Project Management and Approach

A.4 Change management

The following table lists the operational responsibilities and performance expectations that the Bureau has for change management activities.

Change Management Table

Change Management Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
Contractor shall provide monthly reports of all open systems changes, including a three (3) month projection of the estimated release plan.	The report shall be delivered or made available electronically to the Bureau within one week after the end of each month	Monthly	The damage that may be assessed shall be one hundred dollars ($500) per calendar day for each day the system changes report is not made available timely. If the report is received on time but the information	

Change Management Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
			reported is inaccurate or incomplete, the Bureau may assess up to one hundred dollars ($100) per day until an acceptable report is received.	
Contractor shall provide monthly report of total staff time spent by job category on system Maintenance, Modifications and Total (A.6.1)	Produce a monthly staffing report within two weeks after the end of each month (Report shall be cumulative by month for the prior 3 months, including any retroactive updates).	Each month	The damage that may be assessed shall be one hundred dollars ($500) per calendar day for each day an acceptable report is not received, unless waived by the Bureau. If the report is received on time but the information reported is inaccurate or incomplete, the Bureau may assess up to one hundred dollars ($100) per day until an acceptable report is received.	
Contractor shall post in TeamTrack an estimate of effort (A.4.2.3.2)	Produce Change Request response information timely.	Within five (5) business days of Bureau request.	The damage that may be assessed shall be one hundred dollars ($100) per business day for each day an acceptable	

Change Management Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
			response is not received, unless waived by the Bureau. If the report is received on time but the information reported is inaccurate or incomplete, the Bureau may assess up to one hundred dollars ($100) per day until an acceptable report is received.	
Contractor shall provide SCR status meeting minutes within two (2) business days of the meeting.	Produce and distribute meeting minutes within two (2) business days of SCR status meeting.	Within two (2) business days of SCR status meeting.	The damage that may be assessed shall be one hundred dollars ($100) per business day for each day past deliverable period.	
Contractor shall report the age of each open maintenance items and calculate the percentage completed within ten business days	Aging information made available to the Bureau monthly.	Within one week after the end of each month	The damage that may be assessed shall be one hundred dollars ($100) per business day for each day past deliverable period.	
Contractor shall track all stages of work performed within TeamTrack	Update the Bureau's change management tracking tool timely	Within five business days of a change in state	The damage that may be assessed shall be one hundred dollars ($100) per change request not timely tracked as reasonable,	

Change Management Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
			unless waived by the Bureau.	

B.3.3.3 Claims Control and Entry Functions

The Claims Control and Entry functions shall ensure that all paper claims, including UB04, CMS-1500, 94, NCPDP, and crossover claims forms, and related input to the TCMIS are captured in an accurate manner at the earliest possible time. These functions shall monitor the movement and distribution of claim batches once they are entered into the system to ensure an accurate trail from receipt of claims through data entry to final disposition. The function shall include both manual and automated processes for claim control.

Additional objectives of this function of the TCMIS are to:

Maintain control over all transactions during their entire processing cycle.

Provide accurate and complete registers and audit trails of all processing.

Monitor the location of all claims at all times.

It is the responsibility of the Contractor to ensure all Claims Control activities contained within the Contract meet the requirements.

Reference or Contract sections – Listed below: A.3.11 Claims/Encounter Claims

The following table lists the operational responsibilities and performance expectations that the Bureau has for Claims Control and Entry-related activities.

Claims Control Table

Claims Control Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
Assign a unique control number to every claim, attachment, and adjustment request received within one (1) business day of receipt at the Bureau's site.	Produce a report with a random sample of all claims with the date the claim was received and the date control number was assigned.	Within one (1) business day of receipt.	The damage that may be assessed shall be one hundred dollars ($100) per day per claim/attachment for each day past deliverable period.	
Return paper claims missing required data within one (1) business	Produce a report with a random sample of all paper claims returned	Return paper claims within one (1)	The damage that may be assessed shall be one hundred dollars ($100) per	

Claims Control Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
day of receipt.	due to missing data with the date the claim was received and the date the claim was returned.	business day of claim receipt.	day per claim for each day past deliverable period.	
Document image every claim, attachment, and adjustment request within one (1) business day of receipt.	Produce a report with a random sample of all claims, attachments, and adjustments with the date the claim and associated information was received and the date claim or associated information was imaged.	Within one (1) business day of receipt of claim / attachment/ adjustment receipt.	The damage that may be assessed shall be one hundred dollars ($100) per day per claim/ attachment /adjustment for each day past deliverable period.	
Create and store a document image of Bureau-identified reports within one (1) business day of report generation.	Produce a report with a random sample of all reports with the date the report was generated and the date the report was imaged.	Within one (1) business day of report production.	The damage that may be assessed shall be one hundred dollars ($100) per day per report for each day past deliverable period.	
Retain hard-copy documents and claims on-site until the batch is fully adjudicated and the retention schedule has lapsed.	Contractor shall have documents on-site for Quality Control (Q/C) audits to uphold performance requirements.	As frequently as claims batches are received.	The damage that may be assessed shall be one hundred dollars ($100) per day per batch for each day past deliverable period.	
Enter all paper claims within five (5) business days of receipt, unless otherwise approved by the Bureau.	Produce a report with a random sample of all claims with the date the claim was received and the date the claim was entered in the TCMIS.	Within five (5) business days of claims receipt.	The damage that may be assessed shall be one hundred dollars ($100) per day per claim for each day past deliverable period.	
Update the claims entry files daily with electronic transaction-submitted claims.	Produce a report of random sample of claims updated every day.	Daily, or as claims are received.	The damage that may be assessed shall be one hundred dollars ($100) per day per claim for each day past deliverable period.	
Produce, reconcile, and submit to the Bureau, balancing and control reports that reconcile all claims entered into the system to the batch processing cycle input and output counts.	Publish all reports to the report repository, or hardcopy if requested by the Bureau.	Daily, or as frequently as claims are received.	The damage that may be assessed shall be one hundred dollars ($100) per day per report for each day past deliverable period.	

Claims Control Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
Produce and submit to the Bureau, all daily, weekly, and monthly claims reports, including, but not limited to, data entry statistics.	Publish all reports to the report repository. If requested by the Bureau, hard copy claims statistical reports.	Daily, weekly, and monthly, as frequently as claims are received.	The damage that may be assessed shall be one hundred dollars ($100) per statistical report for each day past deliverable period.	

B.3.3.4 Claims/Encounter Pricing and Adjudication

The Claims/Encounter Pricing and Adjudication function accepts and processes claims and encounter transactions input via paper or electronic media. This function shall accept claims/encounters entered through the claims control and entry process, perform extensive validity checks (edits and audits), and adjudicate and price approved claims according to Bureau policy. Claims pricing and adjudication shall be comprised of the following activities:

1) Edit/Audit Cycles - Process claims and encounters through preliminary edits/audits to verify that required fields are present and in the appropriate format, are consistent and reasonable, and contain allowable values. Check for data conflicts between fields within the transaction.

2) Claims Correction - Provide for suspended claims to be accessed and reviewed by claims resolution staff for disposition of the claim (e.g., data corrected, forced, denied, or manually priced), according to Bureau policy.

3) Claims Pricing - After editing, the system shall automatically calculate the allowed amount for claims and encounters according to Bureau policy. The pricing function shall include the ability to accommodate deductions and add-ons to the calculated allowed amount such as enrollee co-payments or payments from other insurance carriers. TennCare enrollees must pay a share of the cost of their health care services, which results in co-payments being required for certain specific services. Pharmacy co-pays apply to TennCare Standard enrollees as well as certain non-institutional Medicaid adults.

4) Claims exceeding the limits or audit criteria shall be reviewed by the Contractor or Bureau staff using the Bureau-approved adjudication guidelines. Corrections to the claims shall be made and applied to the claim record. Claims that do not exceed any of the file limits or audit criteria shall be finalized.

5) Claims History - All pending and paid/denied claims and encounters and their disposition (such as claims data, edits/audits applied and processing dates) and encounter claims shall be maintained for each enrollee. Health insurance payments, estate recovery actions, SUR audits, or other adjustments to claims shall also be maintained. This information shall be maintained online then archived for storage according to a Bureau-defined schedule. Certain claims, such as those for once-in-a-lifetime surgical procedures, shall never be purged from online claims history.

6) The Encounter processing function shall process encounter claims as health plan encounter records submitted to the TCMIS under the Bureau's managed care program. This function shall accept, edit, price, and process encounter claims in

accordance with Bureau edit guidelines. Encounter processing shall have limited auditing and history update, and shall bypass the remittance and check write flow.

It is the responsibility of the Contractor to ensure all Claims Encounter activities contained within the Contract meet the requirements.

Reference or Contract sections – Listed below: A.3.11 Claims/Encounter Claims

The following table lists the operational responsibilities and performance expectations that the Bureau has for Claims/Encounters Pricing and Adjudication-related activities.

Claims / Encounter Adjudication Table

Claims / Encounter Adjudication Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
Meet all CMS and audit review processing requirements.	Publish reports to the report repository that demonstrate the Contractor meets all CMS and audit processing requirements.	Agreed upon timeframe whenever required by CMS and the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per day per audit requirement for each day past deliverable period, if not completed by the agreed upon timeframe.	
Perform daily claims processing cycles.	Produce a report that documents the time of each daily claim processing cycle.	Each night according to Production schedule.	The damage that may be assessed shall be one hundred dollars ($100) per day per report that claims cycles are late due to Contractor issues.	
Perform online, real-time adjudication of all claims transmitted interactively except for the maintenance period each week, unless otherwise authorized, in advance, by the Bureau.	Produce a weekly summary report of a random sample of adjudicated claims.	Adjudicate claims submitted weekly within thirty (30) calendar days of receipt.	The damage that may be assessed shall be one hundred dollars ($100) per day for each day past the deliverable period, unless waived by the Bureau.	
Process provider-initiated adjustments according to the following standards: Ninety-five percent (95%) within twenty (20) calendar days of receipt.	Produce a report that documents the percent of provider-initiated adjustments processed within twenty (20) days and thirty (30) days by provider-initiated adjustment receipt date as currently produced today.	Within twenty (20) days of adjustment receipt; or within thirty (30) days of receipt.	The damage that may be assessed shall be one hundred dollars ($100) per adjustment that is not processed within the specified timeframes.	One hundred percent (100%) within thirty (30) calendar days of receipt.

Claims / Encounter Adjudication Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
Provide the Bureau with document imaging, facsimiles, or hard-copy original claims, adjustments, attachments, non-claim transaction documents, and all electronic billings for all transactions processed within five (5) business days, upon request.	Produce a report that documents all requests associated with document imaging, facsimiles, or hard-copy original claims, adjustments, attachments, non-claim transaction documents, and all electronic billings for all transactions with the date the request was received by the Contractor and the date the requested information was received by the Bureau.	Within five (5) business days of transaction receipt.	The damage that may be assessed shall be one hundred dollars ($100) per day per document or transaction for each day past the deliverable period.	

B.3.3.5 Claims Reporting and Financial Processing

The Claims Reporting and Financial processing function provides the overall support and reporting for all of the claims processing and financial activities necessary to support the Tennessee medical assistance programs. It includes activities for claim payment processing, adjustment processing, accounts receivable processing, and financial transaction processing. This function ensures that all Bureau funds are appropriately disbursed for claim payments and that all post-payment transactions are applied accurately.

The Claims Reporting and Financial Processing function is the last step in claims processing. It provides the detailed information for provider checks, provider claim reports, and the financial reports. It includes:

1) Payment Processing - Claims that have passed all edit, audit, and pricing processing, or which have been denied, are passed on for payment processing.

2) Adjustment Processing - Adjustments to be processed in the regular claims processing cycles.

3) Other Financial Processing - Financial transactions such as voids, credits, returned warrants, manual checks, cash receipts, repayments, recoupments, cost settlements, accounts receivable, cash receipts, canceled warrants, levies, garnishments and non-claim-related system payments (payouts) will be processed as part of the Claims Reporting and Financial function.

It is the responsibility of the Contractor to ensure all Claims Reporting and Financial Processing activities contained within the Contract meet the requirements.

Reference or Contract sections – Listed below:

A.3.9 Accounting/Financial/Premium Management

A.3.11 Claims/Encounter Claims

The outputs of the Claims Reporting and Financial Processing function shall meet all federal and State reporting requirements, and shall provide the information necessary to assess compliance with federal certification and audit review standards. The outputs shall be produced on paper, document imaging, online display, direct transmission, and electronic media, as directed by the Bureau.

The following table lists operational responsibilities and performance expectations that the Bureau has for Claims Reporting and Financial-related activities.

Claims Reporting and Financial Processing Table

Claims Reporting, Financial processing Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
Contractor shall be responsible for timeliness of issuing payment files	Claims File or financial transaction is transmitted after Bureau approval and prior to the financial system cutoff for the intended check date.	Per financial cycle	The damage that may be assessed shall be one thousand dollars ($1,000) for any transmission that cannot be submitted within one day of the intended date.	
Perform at least one (1) payment cycle weekly on a schedule to be approved by the Bureau.	Produce a report that documents the date and time of each weekly payment cycle and the Bureau scheduled date and time for the payment cycle.	At least weekly, according to production schedule.	The damage that may be assessed shall be one hundred dollars ($100) per day the payment cycle is delayed from approved Bureau schedule due to Contractor issues.	
Generate and distribute enrollee EOMBs no less frequently than every quarter.	Report to the Bureau the date EOMBs are sent to enrollees	At least quarterly	The damage that may be assessed shall be one hundred dollars ($100) per day the distribution of EOMBs is delayed due to Contractor issues.	
Produce, and make available to the Bureau, the claims inventory, operations, and other reports after each claims processing cycle.	Publish all reports to the report repository, and by hardcopy if requested by the Bureau.	According to the frequency of claims processing cycle.	The damage that may be assessed shall be one hundred dollars ($100) per day per claims cycle report for each day past deliverable period.	
Make available all financial reports for online viewing to the Bureau within one (1) business day of the financial cycle.	Publish all reports to the report repository, or hardcopy if requested by the Bureau.	Within one (1) business day after financial cycle.	The damage that may be assessed shall be one hundred dollars ($100) per day per financial report, that the reports are not available for online	

Claims Reporting, Financial processing Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
			viewing.	
Produce, and submit to the Bureau, weekly and monthly reports on accounts receivable collections and outstanding balances, with individual detail and aggregate totals .	Publish all reports to the report repository, or hardcopy if requested by the Bureau.	Within one (1) business day after financial cycle.	The damage that may be assessed shall be one hundred dollars ($100) per day per report, that the weekly reports are late due to Contractor issues.	
Process all Bureau-approved mass adjustments in the next weekly payment cycle.	Produce a report that documents the date of each mass adjustment and the date of the payment cycle that contained the mass adjustments.	As required by the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per week the mass adjustments are delayed from processing due to Contractor issues.	
Process to completion all adjustments resulting from system-caused or Contractor-caused errors.	Produce a report with a random sample of all adjustments resulting from system-caused or Contractor-caused errors with the date the adjustment was identified and the date the adjustment was processed.	Within the later of twenty-five (25) calendar days of identification, or as directed by the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per day per adjustment error if delayed from processing due to Contractor issues.	
Accommodate all Bureau requests for system-generated adjustments in a timely manner, (e.g. large corrections from inappropriate payments reported to the Bureau, State or federal audits, or retroactive Bureau policy changes.)	Produce a report that lists when adjustment requests were made and the date they were actually done. If adjustment requests exceed five (5) business days, damages may be assessed.	Within five (5) business days of scheduled process, or of Bureau request.	The damage that may be assessed shall be one hundred dollars ($100) per day that the system-generated adjustments are not processed after scheduled or the Bureau requested date.	
Create weekly sample from which to perform quality control testing.	Produce a list with the weekly sample.	Weekly or as required by the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per day the weekly Q/C sample is late from processing or delivery.	
Update system and operations	Produce a report that lists when system	Monthly, or when requested	The damage that may be assessed shall be one	

Claims Reporting, Financial processing Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
documentation within ten (10) business days of when system changes are made and update detail systems design documents (DSDs) quarterly.	changes are made and when system and operations documentation are actually updated.	by the Bureau, or at least quarterly.	hundred dollars ($100) per day per systems change for which systems change / operations documentation / DSD is not updated.	

B.3.3.6 General Subsystems/TCMIS

The Contractor shall operate and maintain the TCMIS subsystems and perform the Contractor responsibilities listed in the subsections below. This list may not be all inclusive. It is the responsibility of the Contractor to ensure that all General Subsystem Activities contained within the Contract meet the requirements.

Reference or Contract section – Listed below:
A.3.2 Integration and Interfaces A.3.3 Eligibility and Enrollment A.3.4 Correspondence, Letters and Notices A.3.5 Complaints/Grievances/Appeals A.3.6 Benefit Packages A.3.7 EPSDT A.3.8 Medicare Buy-In A.3.10 Drug Rebate A.3.12 Third Party Liability A.3.13 Reference A.3.14 Long Term Care Business Unit A.3.15 Program Integrity/SURS/Fraud and Abuse A.3.16 Managed Care A.3.17 MAR A.3.18 Provider A.3.19 EDI

B.3.3.7 Provider Subsystem

The Provider Subsystem maintains comprehensive current and historical information about all providers, including, but not limited to, medical and non-medical providers and managed care entities that are eligible to participate in TennCare. It ensures that only eligible providers who agree to comply with the program rules and regulations are reimbursed for furnishing services to eligible enrollees.

The following table lists the operational responsibilities and performance expectations that the Bureau has for Provider related functions.

Provider Table

Provider Commitments	**Performance Indicators**	**Deliverable Period**	**Liquidated Damages**	**Additional Assessment Criteria**
Submit to the Bureau on a timely basis all Provider Subsystem reports according to the schedule determined by the Bureau.	Produce Provider reports according to schedule.	Within five (5) business days of scheduled process, or upon Bureau request.	The damage that may be assessed shall be one hundred dollars ($100) per day that the scheduled reports are not processed after scheduled or the Bureau requested date.	

Provider Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Operate and support the AVRS system to support provider inquiries	Notify Bureau management if AVRS is not available.	Twenty-four (24) hours per day, seven (7) days per week, excluding scheduled maintenance periods.	The damage that may be assessed shall be one hundred dollars ($100) per day that the AVRS component is not functioning correctly due to Contractor issues.	
Provide online access and updates to Provider data within normal business hours.	Notify Bureau management if online access is not available.	Daily	The damage that may be assessed shall be one hundred dollars ($100) per day that the Provider component is not available due to Contractor fault.	

B.3.3.8 Eligibility Subsystem

The primary purpose of the Eligibility Subsystem is to accept and maintain an accurate, current, and historical source of eligibility and demographic information on individuals who have been or currently are eligible for TennCare. The maintenance of enrollee data is required to:

Support fee-for-service (FFS) and encounter claims processing, third-party liability cost-avoidance and recovery, managed care payment processing, health insurance and Medicare premium payment processing, and management and administrative reporting functions.

Accomplish automated interfaces with other systems.

Provide eligibility verification data to providers and other parties. The enrollee data maintained in this area also supports the maintenance of enrollee benefit limitations and the generation of various enrollee reports.

Up to twelve (12) years of TennCare eligibility data shall be maintained by the Contractor in an electronic file in the TCMIS. Updates to this file shall be received through electronic transactions. Refer to Section A.3.2.1 for the Interface Listing.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Eligibility related functions.

Eligibility Table

Eligibility Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Produce, and submit to the Bureau, balancing and maintenance reports from the daily, weekly and monthly	Produce a report that lists the report name, documents the delivery date and time of all reports, and the Bureau staff	By the business day following the update.	The damage that may be assessed shall be one hundred dollars ($100) per day that the scheduled reports are	

Eligibility Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
update process.	member that received the report.		not delivered according to schedule.	
Complete processing of ME packet within three (3) business days of receipt.	Upon notice of a deficiency, Contractor shall propose a CAP to remedy deficiency.	Within three (3) business days of receipt of ME packet.	The damage that may be assessed shall be twenty-five (25%) of current price per ME Packet that is incomplete after three (3) business days up to a maximum of five hundred dollars ($500) per month.	If CAP remedy is not completed, damages may be assessed.

B.3.3.9 Out-Bound Correspondence, Letters and Notices

The Contractor shall be responsible for a variety of official correspondence, letters, and notices related to eligibility application approval and denial, enrollment, premium billing, dunning notices, information verification letters, legal matters, EPSDT services, TPL questionnaires, complaints, grievances and appeals, and member services correspondences. Most all correspondence and notice items have strict distribution deadlines.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the correspondence related activities.

Correspondence Table

Out-Bound Correspondence Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Ensure production of correspondence, letters and notices are within twenty-four (24) hours of receipt of print files if they are printed by the Contractor.	Produce a report that contains correspondence statistics, along with random samples of each type of correspondence for verification.	Within twenty-four (24) hours of receipt of print files.	The damage that may be assessed shall be one hundred dollars ($100) per day until correspondences are produced.	
Mail outgoing correspondence timely	Provide the Bureau with access to a log of mailing dates and volumes by correspondence type	Within Bureau specified timeline after receipt of printed materials.	The damage that may be assessed shall be one hundred dollars ($100) per day until correspondences are mailed if due to Contractor fault.	
Contractor shall perform quality control reviews on all generated correspondences within	Maintain control documents that lists correspondence tracking data (e.g., type produced, quantity, date	Within twenty-four (24) hours (or Bureau	The damage that may be assessed shall be one hundred dollars ($100) per day until	

Out-Bound Correspondence Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
twenty-four (24) hours of receiving printed documents.	quality controlled, date released for mail processing),	specified timeline) of receipt of printed documents.	correspondences are verified.	

B.3.3.10 EPSDT

The Contractor shall commit to supporting EPSDT functions, which includes notification processes to enrollees to remind them of services and inform them of health screenings.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the EPSDT related activities.

EPSDT Table

EPSDT Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Support EPSDT processes to generate and mail monthly EPSDT notices.	Produce associated EPSDT processing control report and deliver within five (5) business days of schedule.	Within five (5) business days of monthly schedule.	The damage that may be assessed shall be five hundred dollars ($500) per day until notices are produced and mailed.	
Produce quarterly CMS-416 EPSDT report according to Bureau specifications.	If the report is not produced within five (5) business days of due date (according to production schedule), or is inaccurate due to the fault of the Contractor, the Bureau may assess damages until remedied.	Quarterly and Annual, according to schedule.	The damage that may be assessed shall be five hundred dollars ($500) per day after the due date until report is produced.	
Receive and process interface files (DOH weekly immunization data & MCO EPSDT screening files)	Contractor shall produce associated reports and deliver within five (5) business days according to production schedule.	Weekly or as required by the Bureau.	The damage that may be assessed shall be five hundred dollars ($500) per day after the due date until updates are processed.	

B.3.3.11 Medicare Buy-In

The Medicare Buy-In function maintains and reports Medicare premium information that is used in Eligibility, Enrollment and Financial and Accounting functions.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Medicare Buy-In activities.

Medicare Buy-In Table

Medicare Buy-In Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Support Medicare Buy-In processes to maintain Buy-in data using Medicare update transactions.	Produce associated Buy-in processing reports within five (5) business days of production schedule.	Monthly, within five (5) business days of schedule	The damage that may be assessed shall be one hundred dollars ($100) per day after the due date until updates are processed.	
Generate premium payments for Medicare Buy-In enrollees.	Produce associated Buy-in premium processing reports within five (5) business days of production schedule.	Monthly, within five (5) business days of schedule	The damage that may be assessed shall be one hundred dollars ($100) per day after the due date until payments are generated.	

B.3.3.12 Reference

The TCMIS Reference function maintains pricing files for procedures, drugs, and DRGs, and maintains other general reference files such as diagnosis, edit/audit criteria, edit dispositions, and error and remittance text information, including, but not limited to, benefit limit criteria and provider-specific rates for procedure codes. It provides a consolidated online source of reference information to be accessed during processing by other functions of the TCMIS, including, but not limited to, such areas as the claims processing, TPL functions, and managed care reporting functions.

The Bureau's goals in the maintenance of reference data are to:

1) Provide accurate coding and pricing verification during claims processing for all approved claim types, assistance programs, and reimbursement methodologies, including, but not limited to, capitated and fee-for-service programs.

2) Maintain flexibility in reference parameters and file capacity to make the TCMIS capable of easily accommodating changes and updates in coding standards in the Tennessee medical assistance programs.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Reference related activities.

Reference Table

Reference Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Correctly apply all reference file/database/online updates and interfaces within the Bureau-	Produce a report that lists all reference updates and the date when interfaces were actually updated.	Within five business days of Bureau approval of the update or	The damage that may be assessed shall be one hundred dollars ($100) per day after the due date until updates	

specified time frames.		agreed upon time frames.	are processed.	
Deliver weekly, monthly, bimonthly, and quarterly Reference reports, as defined by the Bureau, including specially requested reports.	Post reports to the report repository and update compliance dashboard, as appropriate	Within five (5) business days of update receipt.	The damage that may be assessed shall be one hundred dollars ($100) per day after the due date until reports are produced.	
Update drug file data, including, but not limited to, pricing information, using the file received from the Bureau-approved drug file updating service on a bimonthly basis.	Produce a report that lists the date the drug file is updated.	Within five (5) business days of receipt of the update data.	The damage that may be assessed shall be one hundred dollars ($100) per day after the due date until update is processed.	

B.3.3.13 Long Term Care Business Unit

The Long Term Care Business Unit performs several functions to support the coordination of care services for LTC enrollees. These functions include Quality Monitoring, monitoring LTC provider claims payments, managing PAEs, LTC appeals, and performing file maintenance functions.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Long Term Care related activities.

LTC Table

LTC Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Provide online notification to providers within twenty-four (24) hours of transmission.	Notify providers within twenty-four (24) hours that files have been received.	Within twenty-four (24) hours of receipt of provider files.	The damage that may be assessed shall be one hundred dollars ($100) per day per provider that notifications are not generated.	

B.3.3.14 Electronic Transactions

The State of Tennessee requires medical assistance programs providers who bill claims to submit their claims electronically, unless exempted by the Bureau. Electronic transactions allow providers to submit claims either interactively using the Tennessee Web Portal accessible from their personal computers or through national standard formats in batch submission through electronic data transmission. All claims submitted through electronic transactions shall be edited against the most current enrollee, provider, and reference files/database tables. Claims shall be assigned transaction control numbers immediately upon receipt and are downloaded nightly to the TCMIS for processing. Claims failing these edits shall be rejected for correction and resubmission. The definition of electronic claims transactions, as used in this Contract, refers to

prepayment editing, response, and acceptance of claims submitted online, via point-of-sale (POS) technology or direct data transfer, with adjudication of claims through pricing.

The following table lists the operational responsibilities and performance expectations that the Bureau has for electronic transactions related activities.

Electronic Transactions Table

Electronic Transactions Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Provide online response notifications to providers within sixty (60) seconds or less for interactive claims.	Provide response notifications and post to the compliance dashboard the results of a weekly random sample of all online interactive provider responses with the date and time the claim was received and the date and time of the response notification.	Within sixty (60) seconds or less for interactive claims.	The damage that may be assessed shall be one hundred dollars ($100) per response that exceeds the time limitation.	
Notify providers by a confirmation notice for batch transactions through standard X12N transactions.	Send the confirmation notice post to the compliance dashboard the results of a QC random sample produced weekly of all X12N transaction confirmation notices with the date and time the X12N transaction was received and the date and time the confirmation notice was sent.	Within 1 hour after completion of the translation and compliancy verification	The damage that may be assessed shall be one hundred dollars ($100) per response that exceeds the time limitation due to Contractor fault.	
Produce and submit to the Bureau, all electronic claims submission reports	Publish all reports to the report repository, or hardcopy as requested by the Bureau.	By COB of the next business day.	The damage that may be assessed shall be one hundred dollars ($100) per report per day if not received.	
Load electronically submitted claims to the claims engine.	Load claims and post to the compliance dashboard the results of a weekly QC random sample of all electronically submitted claims with the date and time the claim was received and the date and time the claim was loaded.	Within one (1) business day of receipt of Bureau approval by the Contractor.	The damage that may be assessed shall be one hundred dollars ($100) per claim per day if not loaded.	
Process all batch submittals timely	Process submittals and post to the compliance dashboard the results of a	For routine volumes, within four (4) hours	The damage that may be assessed shall be one hundred dollars	

Electronic Transactions Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
	weekly QC random sample of all batch submittals with the date and time the batch was received and the date and time the batch was loaded.	after loading. For high volume submittals, within two (2) business days after loading.	($100) per day per batch.	

B.3.3.15 Drug Rebate Program

The TCMIS Drug Rebate Subsystem ensures compliance with the Centers for Medicare and Medicaid Services (CMS) Drug Rebate program, established under OBRA 90. Under the Drug Rebate Program, the TennCare Program recovers cash rebates from drug manufacturers whose products are used by TennCare Program enrollees. On a quarterly basis, CMS sends a file to the State of Tennessee. This file contains National Drug Codes (NDCs), the rebate per unit amount determined by CMS using manufacturer-supplied data, and NDC correction records from previous quarters. The Drug Rebate Subsystem shall track pharmacy claims for drugs and invoices drug manufacturers using drug information and rebate amounts specified by CMS. The TCMIS shall generate quarterly invoices to drug manufacturers.

The Drug Rebate Subsystem shall maintain drug manufacturer information, records and remittance advices received from manufacturers with their rebate payments, and tracks manufacturers' adjustments and disputes, and dispute resolution. It shall also provide a crosswalk of C, J, Q, and S HCPC codes.

The Drug Rebate Subsystem shall maintain an invoice history database that contains all the NDC-level items that have been printed on the quarterly drug rebate invoices. Each entry in the database shall contain a complete audit trail of one (1) specific service quarter's NDC-level invoice item from its initial invoice to its latest appearance on an adjustment invoice. Invoice data is available for online inquiry and update. The Drug Rebate Subsystem shall allow a user to manually adjust invoice line items to assist in the adjustment and dispute resolution processes. The invoice history database shall also provide an audit trail of the manually entered adjustments and flags them for inclusion on the next adjustment invoice. Data shall be maintained on the invoice history database for a minimum of eighty-four (84) months. All disputed codes shall be kept on the database until resolved.

Drug Rebate shall automatically assess interest to the manufacturer on past-due invoice items. Interest is calculated using weekly U. S. Treasury Bill rates and is recorded at the manufacturer level. Interest shall not be calculated on items in dispute, but shall be charged after the dispute is resolved. Interest shall be charged retroactively from the date the disputed amount was originally due.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Drug Rebate related activities.

Drug Rebate Table

Drug Rebate Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Process the CMS Drug Rebate file.	Process the file and update the compliance dashboard with the dates the file was received and processed.	Within one (1) business day of Bureau approval	The damage that may be assessed shall be one hundred dollars ($100) per file if not processed within required time period, due to Contractor issues.	
Generate draft invoices and send to Bureau for review.	Generate draft invoices and update the compliance dashboard with the date the drug rebate cycle is completed and the date the drug rebate cycle draft invoices are generated.	Within three (3) days of the completion of the drug rebate cycle.	The damage that may be assessed shall be one hundred dollars ($100) per day if invoices are not sent to Bureau for review, due to Contractor issues.	
Mail invoice statements to manufacturers.	Mail approved invoices and update the compliance dashboard with the date when the drug rebate invoice statements are mailed to manufactures and the quarter for the invoice.	By the first day of the third month following the calendar quarter.	The damage that may be assessed shall be one hundred dollars ($100) per day if invoices are not mailed due to Contractor issues	
Generate draft CMS rebate file, and send file to Bureau for review and approval, after invoice audits but before generation of the CMS file.	Produce draft CMS rebate file and update compliance dashboard with the date the file is sent to the Bureau.	Ten (10) business days prior to generation of CMS Quarterly file.	The damage that may be assessed shall be one hundred dollars ($100) per day if rebate reporting data is not sent for Bureau review.	
Generate Bureau approved final CM file within ninety (90) days of the end of the calendar quarter.	Produce final CMS rebate file and update compliance dashboard with the date the file is sent to CMS.	Within ninety (90) days from the end of the calendar quarter.	The damage that may be assessed shall be one hundred dollars ($100) per day that rebate file is late.	

B.3.3.16 Third Party Liability (TPL)

The current Third Party Liability (TPL) Subsystem maintains comprehensive current and historical information to support the benefit recovery functions of the Tennessee TCMIS. The Bureau uses this information to reduce its liability to pay for enrollee claims. The TPL Subsystem shall ensure that the medical assistance programs are the payer of last resort. This shall be accomplished through a combination of activities, including, but not limited to: 1) cost-avoidance (denial of payment) at the beginning of claims processing, 2) post-payment billing to private insurers when cost avoidance is not possible or when retroactive TPL coverage is added or extended, 3) benefit

recovery functions when retroactive TPL coverage is added or extended, and 4) recovery from deceased enrollees' estates for services that were rendered while they were eligible.

The TCMIS shall use information gathered from a number of sources to identify liability for medical services. These shall include Medicare cross-over claims, Buy-In information, file matching with other government or private programs, and data received from county offices and the Social Security Administration. Interfaces with the Bureau's child support system and the worker's compensation program shall be maintained to obtain additional information related to third-party resources.

The Contractor shall be responsible for most automated processes related to TPL. In addition, some manual TPL-related functions shall be handled by the Contractor with ongoing coordination with the Bureau, primarily in the area of federally-mandated post-payment recovery. Bureau staff have the ultimate responsibility for collection and verification of TPL, purchase of Medicare and health insurance coverage, application of (and exceptions to) TPL utilization requirements, development of policy, development and update to TPL procedures, and coordination with CMS and other State, federal, local, or private organizations.

It is the responsibility of the Contractor to ensure all TPL activities contained within this Contract meet the requirements.

> Reference or Contract section – Listed below:
>
> A.3.12 Third Party Liability

The following table lists operational responsibilities and performance expectations the Bureau has for the TPL related activities.

TPL Table

TPL Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Process enrollee resources information received from the TPL contractor on a weekly basis.	Produce a report that lists the date when the TPL contractor information was received and the date the files were processed.	Weekly, within twenty-four (24) hours of receipt.	The damage that may be assessed shall be one hundred dollars ($100) per day if TPL data from TPL contractor is not processed when received, due to Contractor issues.	
Update the carrier file/database table with information received from TPL contractor on a weekly basis or within twenty-four (24) hours of receipt of an updated request.	Produce a report that lists the date and time when the TPL contractor information was received and the date and time the files were processed.	Within twenty-four (24) hours of receipt of a request.	The damage that may be assessed shall be one hundred dollars ($100) per day if carrier data from TPL contractor is not processed when received, due to Contractor issues.	
Provide monthly status	Produce a report that lists	By the tenth	The damage that may	

TPL Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
summaries of post-payment recovery billings to the Bureau by the tenth (10th) day of each month.	when status summaries were created and the date when they were actually reported to the Bureau.	(10th) day of each month.	be assessed shall be one hundred dollars ($100) per day if summaries are not received by required period, due to Contractor issues.	
Provide copies of document imaged claims to the Bureau within three (3) business days of request.	Produce a report that lists the date when the Bureau request was received and the date the imaged document copy was received by the Bureau.	Within three (3) business days of request.	The damage that may be assessed shall be one hundred dollars ($100) per request of imaged document.	

B.3.3.17 Managed Care

The Bureau is responsible for the implementation and administration of Tennessee's managed care Medicaid and Child Health Plan Plus programs.

The Managed Care Subsystem of the TCMIS shall manage:

1. The contracting of a variety of managed care entities. Managed care providers may be mental health, dental, and/or medical health providers. The various types include Managed Care Organizations (MCOs), Dental Benefits Manager (DBM), Pharmacy Benefits Manager (PBM), and the Program of All-Inclusive Care for the Elderly (PACE).

2. Eligibility and enrollment of recipients. Managed care enrollment is mandatory for all recipients, excluding QMB and SLMB.

3. Payment of monthly capitation (premiums) to managed care entities.

4. Processing of encounter claims from designated managed care entities.

It is the responsibility of the Contractor to ensure all Managed Care activities contained within this Contract meet the requirements.

> Reference or Contract section – Listed below:
>
> A.3.16.4 Contractor Requirements for Managed Care

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Managed Care related activities.

Managed Care Table

Managed Care Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Process payment rate updates prior to the next	Produce a report that lists the date when the rate	Prior to the next	The damage that may be assessed shall be	

Managed Care Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
processing cycle.	updates were received by Contractor, the date the rates were processed, and the date of the next processing cycle after the rates were received.	processing cycle.	one hundred dollars ($100) per day if payment rates are not updated prior to required period.	
Process and complete managed care system cycles before the start of the following business day.	Produce audit reports to show system cycle process information.	Within four (4) hours of start of the following business day,	The damage that may be assessed shall be one hundred dollars ($100) per day if managed care cycles are not run according to production schedule due to Contractor issues.	
Deliver all extract files within time frames specified by the Bureau.	Produce audit reports to show extract files produced and statistical information.	Within four (4) hours of the start of the following business day, or according to production schedule.	The damage that may be assessed shall be one hundred dollars ($100) per day if extract files are not received according to required timeframes, due to Contractor issues.	

B.3.3.18 Management and Administrative Reporting (MAR)

The TCMIS Management Reporting function shall provide information retrieval and reporting which supports policy planning, program evaluation and decision-making, fiscal planning and control, federal reporting, and operational planning and control. Information shall be retrieved from various TCMIS files/database tables for analysis and summarization.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Management Reporting functions.

MAR Table

MAR Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Deliver management reports to appropriate Bureau staff within the time frames established by the Bureau.	Produce MAR reports according to production schedule.	Monthly, within five (5) business days from expected due date.	The damage that may be assessed shall be one hundred dollars ($100) per day if MAR reports are not received according to required timeframes, due to Contractor issues.	

MAR Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Retain final output files for at least twelve (12) months.	Date final output files were produced and the date when they were discarded, monitored through a log.	Twelve (12) month period.	The damage that may be assessed shall be one hundred dollars ($100) per day if MAR reports are not retained until the report is re-created or the 12 month period lapses.	
Respond to Bureau requests for information about the reports with a resolution	When the report request was received and the date when the report response was received, monitored through a log.	Within three (3) business days of request or as agreed with the Bureau	The damage that may be assessed shall be one hundred dollars ($100) per day per report resolution.	
Perform necessary corrections, rerun, verify, and distribute management reports.	Reproduce corrected reports.	Within three (3) business days of problem identification or as agreed with the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per day per report.	
Generate accurate CMS reports.	Produce CMS reports within required timeframe.	Prior to the federal deadline on the schedule agreed with the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per day per report that CMS reports are late due to Contractor issues.	

B.3.3.19 Surveillance and Utilization Review (SUR)

The SUR function shall identify, report and support the investigation of potential misuse of the medical assistance programs by providers and enrollees. The Surveillance and Utilization Review Subsystem (SURS) shall create a comprehensive statistical profile of the delivery of health care services and supplies by provider and the utilization of these services and supplies by enrollee. It shall analyze historical data, develop profiles of health care delivery, and report those users whose patterns of care or utilization deviate from normative patterns of health care delivery. In addition to the identification process, the SUR function shall provide peer group and individual-level reports which support the investigative process.

This function is a management tool to allow the Bureau to evaluate the delivery and utilization of medical care, on a per-case basis, to safeguard the quality of care and to guard against fraudulent or abusive use of the Tennessee medical assistance programs, by either enrollees or providers. These functions shall be performed for the fee-for-service and the managed care programs. The Contractor shall be responsible for the operation and maintenance of the SUR subsystem of the TCMIS.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the SUR function.

SUR Table

SUR Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Maintain the most current sixty (60) months of paid claims and encounter claims and adjustment history, and update monthly, to support SURS reporting as directed by the Bureau.	Produce a statistics report that lists information on current claims and encounter claims that are within sixty (60) months old.	Quarterly, or as required by the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per day per record that is found to not be retained, and is within the required time period, due to Contractor issues.	
Generate and deliver all monthly reports to the Bureau by the fifth (5th) business day following the day the SURS database was updated.	Contractor shall ensure that SURS reports are delivered by the specified timeframe.	By the fifth (5th) business day following SURS database update.	The damage that may be assessed shall be one hundred dollars ($100) per report that is beyond the required time period, due to Contractor issues.	

B.3.3.20 General System Contractor Requirements

The TCMIS Contractor shall be expected to meet all of the general requirements listed in the sections below during the term of this Contract. The general requirements apply to all phases. This list may not be all inclusive. It is the responsibility of the Contractor to ensure all General System Activities contained within this Contract meet the requirements.

Reference or Contract section – Listed below:

A.3.20 Facilities manager General Operations

The following table lists the Contractor's general TCMIS operational responsibilities and performance expectations that the Bureau requires.

General TCMIS Operations Table

General TCMIS Operations Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Contractor shall safeguard access for data integrity according to HIPAA and state security and confidentiality requirements.	Contractor negligently allows Breach of Security.	Continually safeguard the system.	The damage that may be assessed shall be five hundred dollars ($500) for each security / confidentiality breach occurrence.	Contractor may be further liable for any damages imposed on the Bureau by the State or federal government.
Contractor shall conduct	Disaster Recovery shall be demonstrated for	According to Project In	The damage that may be assessed shall be	

General TCMIS Operations Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
demonstration of Disaster Recovery Plan (DRP)	completeness and approved by the Bureau.	conjunction with the Bureau's demonstration of its DRP.	one hundred dollars ($100) per calendar day beginning the first (1st) day of the month in which the disaster recovery capabilities were scheduled to have been demonstrated until the demonstration is complete and approved by the Bureau.	
Contractor shall submit an Annual Business plan for Bureau acceptance.	Acceptable Annual Business plan is submitted to Bureau.	Contract start date and annually thereafter.	The damage that may be assessed shall be one hundred dollars ($100) per calendar day for each day an acceptable Annual Business Plan is not timely received.	
The Contractor shall work with the Bureau to comply with audit findings.	Comply with Bureau requirements as a result of audit findings.	Dates will be specified by the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per day after due date.	The Contractor may also be held responsible for any and all additional liquidated damages imposed on the Bureau by the State or federal government if finding was because of Contractor negligence.

B.3.3.21 Operations

The Contractor shall operate and maintain the TCMIS system and perform the Contractor responsibilities listed in the subsections below. All TCMIS and Facilities Manager functions shall be performed by the Contractor according to the State Medicaid Manual, all federal mandates, and all Bureau requirements, statutes, and regulations. This list may not be all inclusive. It is the responsibility of the Contractor to ensure all Operational Activities contained within the Contract meet the requirements.

Reference or Contract section – Listed below:

A.1 TCMIS Project Management

A.1.3 Project Start-up Approach

A.3.20 Facilities Manager General Operations

A.5 General Facilities Management Contractor Requirements

The following table lists the general TCMIS operations responsibilities and performance expectations that the Bureau has for the Contractor.

General Operations Expectations Table

General Operations Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Contractor shall accept responsibility for the accuracy of systems and operations documentation	Contractor shall maintain all documentation and comply with delivery requirements.	Contractor by the Modified Operations start date, and subsequently within five (5) calendar days of notice, to correct documentatio n.	The damage that may be assessed shall be one hundred dollars ($100) per day after due date, until corrected.	The Bureau will provide prior notice to the Contractor or Contractor Reported Information for required corrections.

B.3.3.22 General Operational Responsibilities

The table on the following page lists general Bureau and Contractor responsibilities required to support the successful operation of the Tennessee TCMIS and its components. More specific requirements and performance standards are further detailed in this Contract. Nothing listed here supersedes other specific requirements listed within this Contract.

This table lists the Contractor's manual TCMIS operation responsibilities and performance expectations that the Bureau requires.

General Manual Operations Table

General Manual Operations Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Deliver to and pick up from the Bureau Mail Center, Contractor mail, reports, and other deliveries as specified by the Bureau.	Produce a daily log that lists the actual pick-up and delivery times to the Mail Center and for package pickup (including time of notification call to the recipient for package pickup).	Once in the morning and once in the afternoon, and as specified by the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per occurrence for each missed courier delivery.	

General Manual Operations Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Document scheduled meetings with the Bureau in writing, summarizing the key points covered, and provide a draft of this summary to the Bureau no later than 4:30 p.m. CT the second (2nd) business day after the meeting.	Produce a report that lists all meetings and documents the delivery date of the meeting documentation.	By 4:30 p.m. CT the second (2nd) business day after the meeting.	The damage that may be assessed shall be one hundred dollars ($100) per day for each meeting report.	This summary shall be prepared in accordance with Bureau-approved format and content criteria.
Submit status reports to the Bureau on a regular weekly schedule and on request.	Produce a report that lists the delivery date of all weekly status reports.	Weekly as scheduled.	The damage that may be assessed shall be one hundred dollars ($100) per day for each status report.	
Provide Bureau-defined extract files, on request, to the Bureau to support special reporting needs.	1) Produce a log that lists all requested extracts, the date the extract was requested, and the date the extract was delivered. 2) Produce extracts	Complete updates to the 1) log within one week of the completion of each extract. 2) Complete extracts by the agreed date with the Bureau.	The damage that may be assessed shall be: 1) one hundred dollars ($100) per occurrence for failure to update the log; 2) one hundred dollars ($100) per day for each extract request not delivered timely.	
Deliver daily, weekly, monthly, and annual reports according to the Bureau-approved schedule and media, and in accordance with the performance expectations defined in the Subsection pertaining to Reports Production Requirements.	1) Produce a log that lists all reports and the date the report was delivered and media that was used, if requested by the Bureau. 2) Produce reports	1) log within one week of the completion of each report. 2) Produce reports as scheduled.	The damage that may be assessed shall be: 1) one hundred dollars ($100) per day for each occurrence for failure to update the log. 2) one hundred dollars ($100) per day for each scheduled report not produced	

B.3.3.23 Training Contractor Requirements

The TCMIS Contractor shall be responsible for developing and delivering a broad spectrum of comprehensive training programs and related documentation and materials. The training materials and approach shall include sufficient information for trainees to accurately and efficiently perform TCMIS related tasks. Proficiency testing, quality control reviews, and where necessary, re-training shall be the responsibility of the Contractor so that the trained personnel demonstrate expected proficiency.

The Contractor shall provide a Training Plan, updated at least annually, that describes the commitment of Contractor staff to providing annual training to all providers and ongoing training to Bureau staff, affiliates, and agents as necessary. The Bureau anticipates that the Contractor shall provide training when new system features or updates have presented significant change and shall provide a training program for new users. It is the responsibility of the Contractor to ensure all Paper Claims and Correspondence Management activities contained within the Contract meet the requirements.

Reference or Contract section – Listed below:

A.3.20.1 Facilities Manager Operational Requirements

A.6.3.15 Trainer

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Training functions.

Training Table:

Training Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Conduct Bureau user training sessions in accordance with the approved Training Plan.	1) Produce a report that lists the training sessions that occurred, the date the training sessions occurred, and the people that attended the training. 2) Deliver training sessions in accordance with the Training Plan	Monthly	The damage that may be assessed shall be: 1) one hundred dollars ($100) per day if training report is not delivered, 2) $500 per session, unless waived by the Bureau.	
Computer Based Training (CBT) and Web Based Training	Training applications are available for Bureau use.	Initial training by Modified Operations start	The damage that may be assessed shall be one hundred	

Training Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
(WBT) applications shall be accessible through a secured Intranet logon environment.		date, and then twenty-four (24) hours per day, three hundred sixty-five (365) days per year thereafter with the exception of Bureau-approved system maintenance periods.	dollars ($100) day that applications are not available due to Contractor issues.	
Provide training materials to the Bureau for review, feedback, comments.	Provide training materials of a newly created or updated materials at least one month prior to the first date of the training session.	One (1) month prior to delivery of a training session.	The damage that may be assessed shall be one hundred dollars ($100) per occurrence that training materials are not delivered in accordance with the Contract.	
Submit an annual detailed Training Plan to the Bureau for approval.	Contractor shall submit a training plan as required.	By September 1, 2009 and by July 1st of each year thereafter.	The damage that may be assessed shall be one hundred dollars ($100) per day after scheduled date, unless waived by the Bureau.	

B.3.3.24 Report Production Contractor Requirements

The Bureau's need for data and information from the TCMIS cannot realistically be met by relying on static production reports. Flexible reporting capabilities shall be supported by system hardware and software components, organizational structures, telecommunication links, knowledgeable staff, and readily available accessible databases; all of which shall work together in an efficient manner.

Required reports consist of numerous reports that are required by the federal government and others which are required by the Bureau or other State agencies.

The following table lists the operational responsibilities and performance expectations that the Bureau has for Reporting functions.

Reporting Table

Reporting Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Contractor shall produce ad-hoc or other on-request reports on the date specified in the report request.	Deliver the ad-hoc report that includes the report name, and other auditable information to show requirement compliance.	By the mutually agreed date	The damage that may be assessed shall be one hundred dollars ($100) per day after scheduled date,	The Contractor may negotiate with requestor if request date or specifications are unrealistic due to report complexity.
Contractor shall deliver all reports by specified timelines.	Produce a report that lists the report name, documents the request date of all reports, documents the delivery date of all reports, and the Bureau staff member that received the report.	Deliver reports by close of business CT of the scheduled delivery date, or as directed by the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per day per report that is not delivered within scheduled timeline.	
All reports, including copies, shall be examined for readability prior to delivery to the Bureau. Report data shall not be accepted in compressed format. Online reports will be formatted to split data into readable views.	For each report, delivered to the Bureau in the quantity and media, and to the user(s) specified by the Bureau	Each day	The damage that may be assessed shall be one hundred dollars ($100) per report if not as specified.	
When a report is not delivered, not delivered in the required format or media, not delivered to the specified user, or does not contain the required number of copies.	Contractor shall be responsible for the timeliness and delivery of all reports and documentation.	Contract start date and daily thereafter	The damage that may be assessed shall be one hundred dollars ($100) per day for each report.	When a report is not delivered, not delivered in the required format or media, not delivered to the specified user, or does not contain the required number of copies.

B.3.3.25 Correspondence Management

The Bureau requests that the Contractor propose a solution to the Bureau's desire to implement a central repository and document management tools to capture, store and index documentation received by both the Bureau and the Contractor. The solution shall show all claims, provider, technical, system and other pertinent documentation and utilize user-intuitive navigation and query tools.

In addition, the Bureau desires that the ability to view document images be available on Bureau staff's individual workstations. The imaging component shall provide the Bureau the capability to access all images captured in the TCMIS. It is the responsibility of the Contractor to ensure all Correspondence Management activities contained within the Contract meet the requirements.

Reference or Contract section – Listed below: A.3. Business Process and Functional Requirements

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Correspondence Management related activities.

Correspondence Management Table

Correspondence Management Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Ensure that all documents are scanned within one (1) business day of receipt.	Contractor shall provide audit information related to scanning processes as requested by the Bureau, and may be audited to randomly sample documents that were scanned and the date/time when the document was received.	Within one (1) business day of receipt	The damage that may be assessed shall be one hundred dollars ($100) per day per document for each day past the deliverable period.	
Retrieve and deliver original hardcopy documentation within two (2) business days of a request by the Bureau.	Produce hardcopy documentation as requested.	Within two (2) business days of a request by the Bureau.	The damage that may be assessed shall be one hundred dollars ($100) per day per request for each day past the deliverable period.	
The Contractor shall generate and distribute correspondence within one (1) business day of an automated or manual request	Produce a statistical report that lists the date when a random sample of generated and distributed correspondence was received and the date of the request.	Within one (1) business day of a request.	The damage that may be assessed shall be one hundred dollars ($100) per day per correspondence for each day past the deliverable period.	
Ensure system response times for searches of stored	Contractor shall develop a method for tracking system response time and produce	Within a five (5) second average	The damage that may be assessed shall be one hundred	

Correspondence Management Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
images shall not exceed a five (5) second average.	a report with an hourly average by day.		dollars ($100) per excessive response time occurrence.	
Ensure that the document imaging system produces complete images, correctly extracts data via ICR, and correctly indexes images.	The Contractor shall perform quality assurance reviews on document imaging processes to ensure that the quality meets contractual requirements.	Deliver assessment monthly .	The damage that may be assessed shall be one hundred dollars ($100) per quality assessment with less than 99.9% accuracy.	

B.3.3.26 Maintenance and Support

The Contractor shall be responsible for maintaining the TCMIS systems and providing maintenance support, and ensuring that the TCMIS is accessible. Maintenance support shall involve all processes necessary to meet the requirements outlined throughout this Contract. The Contractor shall perform all maintenance and support as a routine activity at no additional cost to the Bureau. It is the responsibility of the Contractor to ensure all Maintenance Support activities contained within the Contract meet the requirements.

Reference or Contract section – Listed below:
A.4.1 Maintenance Tasks

The Contractor shall provide sufficient technical staff to perform all routine systems maintenance responsibilities. Examples of maintenance support are:

Assuring claims are received through all specified channels (interactive, batch, and paper) correctly and timely.

Assuring the daily claims processing work including editing and adjudication of claims are conducted smoothly and efficiently.

Correction of defects is made promptly after the Bureau's approval of the plan of correction. A defect is defined as something that does not work according to requirements, or that affects performance standards potentially causing delays in system processing.

Extracts of historical claims are made when needed for appeals, auditors, or other Bureau projects.

Entry of all system lists, parameter, and other table updates.

Performing the activities requested by the Bureau via the official transmittal process.

The following table lists the responsibilities and performance expectations that the Bureau has for the maintenance and support activities.

Maintenance Support Table

Operational Support Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Assure all daily, on-request, weekly, monthly, quarterly, and annual cycles are run correctly and on time.	Provide cycle monitoring information as requested by the Bureau, showing the date all cycles were run and the date when the cycles were scheduled to be run.	Each day.	The damage that may be assessed shall be one hundred dollars ($100) per occurrence where cycles are late or incorrect.	
The Contractor shall monitor all systems processing functions in order to minimize system or payment impact and improve processing.	For issues that arise that cause processing to stop, perform research immediately upon recognizing potential system problems in order to minimize system impact, and simultaneously inform Bureau.	Contact to the Project Director or their designee within one (1) hour. Contact may initially be via telephone but must be followed up with written documentation by end of the following business day.	The damage that may be assessed shall be five hundred dollars ($500) per occurrence if notice is not completed timely.	
Submit report of system errors and failures within one (1) business day of the occurrence.	Produce a report that lists the date when a system error occurred and the date when the error was reported.	Within one (1) business day of the occurrence	The damage that may be assessed shall be one hundred dollars ($100) per day per occurrence for each day past the deliverable period.	
Proactively maintain and upgrade Contractor provided software and hardware to support Contract uptime and response time.	Produce an audit report that lists the date when upgrades were scheduled and the date when the updates actually were performed.	When required	The damage that may be assessed shall be one hundred dollars ($100) per occurrence when upgrades are not maintained as required.	
Assure that the Bureau is notified of all available upgrades of licensed products for the systems, including but not limited to, the OS, databases, and communications,	Produce a report that lists the date when upgrades are available and when Bureau-approved upgrades are scheduled or have been implemented. Available updates should identify impact and any additional	Monthly. Urgent upgrades reported more frequently, as necessary.	The damage that may be assessed shall be one hundred dollars ($100) per occurrence when the report is not delivered timely	

Operational Support Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
excluding the upgrades performed by OIR.	costs.			
Perform work as instructed in official transmittals. This may include extracting data from archived files.	The Contractor shall ensure that official transmittals are used when producing work orders.	As often as required.	The damage that may be assessed shall be one hundred dollars ($100) per occurrence that the transmittals are not used.	

B.3.3.27 Quality Control

The Contractor shall implement and maintain a Quality and Customer Service Assessment System. The following subsections listed below describe the Quality and Customer Service-related activities. This list may not be all inclusive. It is the responsibility of the Contractor to ensure all Quality and Customer Service activities contained within the Contract meet the requirements.

Reference or Contract section – Listed below:

A.5.4 Business Continuity and Contingency Plan (BCCP) – Disaster Recovery

A.5.5 Quality Assurance/Quality Improvement

Quality Control –Enhanced Test Environment

The integrated test facility (ITF) allows the Bureau and the Contractor to monitor the accuracy of the TCMIS and test proposed changes to the system by processing test claims and other transactions through the system without affecting normal operations. The test facility shall mirror production in its files, databases, processing, and reporting. The test facility shall allow for end-to-end testing, from claims entry through the financial and reporting cycles. All system and integration testing shall be performed elsewhere.

The following table lists the operational responsibilities and performance expectations relating to quality control functions upon implementation of the Enhanced Test Environment. Until this implementation, general quality control will be performed through the Control Memorandum(a) process and the general Liquidated Damages provision.

Quality Control Table

Quality Control Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Provide all test outputs within the time period	Produce test output. Also produce an audit report that lists the date when test	As specified according to the project schedule.	The damage that may be assessed shall be one hundred dollars	

Quality Control Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
determined by the Bureau.	output was received and the date when the test output was scheduled to be received.		($100) per day per scheduled test output for each day past the deliverable period.	
Prepare and submit to the Bureau for review a corrective action plan for deficiencies associated with the Test environment.	To remedy a defect, the Contractor shall submit a CAP that documents the date and remedial activity that will be done within a certain timeframe.	Within the agreed-upon time frame.	The damage that may be assessed shall be one hundred dollars ($100) per occurrence that the CAP is not received.	
The Contractor shall provide a report relating to the test cycle against actual processing results, within the agreed-upon time frame.	Provide information relating to test cases versus actual results.	Within the agreed-upon time frame.	The damage that may be assessed shall be one hundred dollars ($100) per day.	
Contractor shall submit system documentation for each scheduled production Release.	System documentation is submitted within the specified timeframes.	Within one business day of the specified timeline.	The damage that may be assessed shall be one hundred dollars ($100) per day that the release documentation is late.	
Contractor shall submit BCCP and Disaster Recovery Plans to the Bureau.	Submission of the plans within the specified timeframes.	At least sixty (60) days prior to Modified Operations Start Date, and updated annually thereafter	The damage that may be assessed shall be one hundred dollars ($100) per day that the BCCP and Disaster Recovery Plans are late.	

B.3.3.28 System Availability and Interfaces

The TCMIS System, and all of its subsystems and components, shall remain available for claims transactions and for exchanging information through the system Interfaces. Below is a listing of Primary Subsystems and Interfaces. This list may not be all inclusive. It is the responsibility of the Contractor to ensure all Subsystems and Interfaces contained within this Contract meet availability requirements.

Reference or Contract section – Listed below: A.5.5 Quality Assurance/Quality Improvement

The following table lists the operational responsibilities and performance expectations relating to TCMIS system availability.

System Availability Table

System Availability Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
The Contractor shall ensure that the TCMIS online access is available within normal business hours each day, except as approved by the Bureau.	TCMIS disconnections shall not be longer than five (5) minutes in a single occurrence. The Bureau or Contract Administrator shall be notified when connectivity is restored and System availability is verified.	If TCMIS online connectivity is lost for more than five (5) minutes.	The damage that may be assessed shall be five hundred dollars ($500) per normal working hour, or any part of a normal working hour thereof. Total damages may not exceed twenty thousand dollars ($20,000) per week.	The Contractor shall notify the Bureau of system unavailability.
Process all interface files (input and output) within specified timeframes according to functional area requirements.	The Contractor shall maintain daily control log of outgoing and incoming files.	Each day	The damage that may be assessed shall be one hundred dollars ($100) per day that the SDLC is late.	
Ensure that all interface files comply with HIPAA standards and transaction code set rules.	The Contractor shall report to the Bureau of any file exchanges that are not HIPAA compliant.	Daily, or as interface data is exchanged	The damage that may be assessed shall be one hundred dollars ($100) per occurrence that files are not HIPAA compliant, if due to Contractor issue.	The Contractor may be responsible for any related damages imposed on the Bureau.

B.4 Deliverables

The Contractor shall be required to submit to the Bureau certain Deliverables during the Start-up activities, and during the creation and implementation of the system Enhancements. The Liquidated Damages listed in the previous sections shall apply to ensure timely and accurate completion of all Deliverables. This list may not be all inclusive. It is the responsibility of the Contractor to ensure all Start-up, Modification and Enhancement activities, requirements and Deliverables contained within this Contract meet the requirements for timeliness and accuracy.

Liquidated Damages imposed on Deliverables are referenced in Deliverables Timeline Table this Section. . All deliverables shall be assessed by timeliness of the deliverable, and accuracy of the deliverable.

A Liquidated damage assessment for timeliness shall be measured from the expected completion date to the actual completion date, and may be one hundred dollars ($100) per day after due date, until corrected.

A Liquidated damage for accuracy shall be measured from the time the Contractor is given prior notice (or Contractor reported the inaccuracy), until five (5) calendar days after notice is given. The assessment may occur from this date (notification date plus five (5) days), to the date of correction. The liquidated damage assessment for accuracy may be one hundred dollars ($100) per day until correction is received.

Liquidated damage assessments for Deliverables are as follows:

Deliverable	Liquidated Damages	Additional Assessment Criteria
Timeliness of Reports/Recommendations	The damage that may be assessed shall be one hundred dollars ($100) per day.	When a report is not delivered, not delivered in the required format or media, not delivered to the specified user, or does not contain the required number of copies.
Accuracy of Reports/Recommendations	The damage that may be assessed shall be one hundred dollars ($100) per day per report.	Prior Notice to Contractor or Contractor Reported Information Required. If not corrected within five (5) calendar days of notice, assessment may occur from date of notification to date of corrected report delivery.

B.5 Dashboard Performance Metrics Reporting and Supporting Documentation

All information used to calculate the performance metrics shall be stored in tables or databases and accessed through the dashboard software required in the TCMIS enhancement listed in Section A.2.6. Supporting documentation shall be maintained by the Contractor for all performance metric calculations. The supporting documentation for any performance metric shall be delivered to the Bureau within two (2) business days after it is requested.

Attachment C HIPAA BUSINESS ASSOCIATE AGREEMENT

HIPAA BUSINESS ASSOCIATE AGREEMENT

IN COMPLIANCE WITH PRIVACY AND SECURITY RULES

THIS HIPAA BUSINESS ASSOCIATE AGREEMENT ("Agreement") is between **The State of Tennessee, Department of Finance and Administration, Bureau of TennCare,** 310 Great Circle Road, Nashville, TN 37243 ("Covered Entity") and **Electronic Data Systems Corporation and EDS Information Services, LLC,** located at 5400 Legacy Drive, Plano, TX 75024 ("Business Associate"), including all office locations and other business locations at which Business Associate may use or maintain Covered Entity's data. Covered Entity and Business Associate may be referred to herein individually as "Party" or collectively as "Parties."

BACKGROUND

Covered Entity acknowledges that it is subject to the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

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

LIST OF AGREEMENTS AFFECTED BY THIS HIPAA BUSINESS ASSOCIATE AGREEMENT	Execution Date
Contract between State of Tennessee, Dept of Finance & Administration, Bureau of TennCare and Electronic Data Systems Corporation and EDS Information Services, LLC	Current contract as of the signing of this Agreement

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

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

To the extent the American Recovery and Reinvestment Act of 2009 heightens enforcement of federal regulations and enhances protection of PHI or other applicable data, Business Associate agrees to execute an amended Business Associate Agreement to that effect upon request by TennCare.

1. DEFINITIONS

1.1 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 CFR §§ 160.103, 164.304, 164.504 and 164.501.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.2 Privacy Safeguards and Policies. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by the Service Agreement(s), this Agreement or as Required By Law. This includes the implementation of administrative, physical, and technical

safeguards to reasonably and appropriately protect the Covered Entity's PHI against any reasonably anticipated threats or hazards, utilizing the technology commercially available to the Business Associate (See also Section 3.2). The Business Associate shall maintain appropriate documentation of its compliance with the Privacy Rule, including, but not limited to, its policies, procedures, records of training and sanctions of members of its workforce.

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

2.4 Mitigation of Harmful Effect of Violations. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

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

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

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

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

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

c. If the Covered Entity receives a request and requires information from the Business Associate in addition to the Covered Entity's onsite information to fulfill the request, the Business Associate shall

have thirty (30) days from date of Covered Entity's notice to provide access or deliver such information to the Covered Entity so that the Covered Entity may timely respond to the Individual within the sixty (60) day requirement of 45 CFR § 164.524.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.4 Tennessee Consumer Notice of System Breach. Business Associate understands that the Covered Entity is an “information holder” (as may be Business Associate) under the terms of Tenn. Code Ann. § 47-18-2107, and that in the event of a breach of the Business Associate’s security system as defined by that statute and Definition 1.2 of this agreement by an employee, contractor, or authorized user of the Business Associate, the Business Associate shall indemnify and hold the Covered Entity harmless for expenses and/or damages related to the breach. Such obligation shall include, but is not limited to, the mailed notification to any Tennessee resident whose personal information is reasonably believed to have been acquired by an unauthorized individual. In the event that the Business Associate discovers circumstances requiring notification of more than one thousand (1,000) persons at one time, the person shall also notify, without unreasonable delay, all consumer reporting agencies and credit bureaus that compile and maintain files on consumers on a nationwide basis, as defined by 15 U.S.C. § 1681a, of the timing, distribution and content of the notices. Substitute notice, as defined by Tenn. Code Ann. § 47-18-2107(e)(2) and (3), shall not be permitted except as approved in writing in advance by the Covered Entity. The parties agree that PHI includes data elements in addition to those included by “personal information” under Tenn. Code Ann. § 47-18-2107, and agree that Business Associate’s responsibilities under this paragraph shall include all PHI.

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

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

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

Privacy Officer

Bureau of TennCare

310 Great Circle Rd.

Nashville Tennessee

Phone: (615) 507-6855

Facsimile: (615) 532-7322

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

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

4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

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

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

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

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

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

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

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

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

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

5. OBLIGATIONS OF COVERED ENTITY

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

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

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

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

6. PERMISSIBLE REQUESTS BY COVERED ENTITY

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

7. TERM AND TERMINATION

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

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

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

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

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

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

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

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

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

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

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

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

8. MISCELLANEOUS

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

8.2 Amendment. The Parties agree to take such action to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act, Public Law 104-191. Business Associate and Covered Entity shall comply with any amendment to the Privacy and Security Rules, the Health Insurance Portability and Accountability Act, Public Law 104-191, and related regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended.

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

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

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

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

other Party of changes in address, telephone number, fax numbers and to promptly supplement this Agreement as necessary with corrected information. **Notifications relative to Sections 2.5, 3.4 and 3.5 of this Agreement must be reported to the Privacy Officer pursuant to Section 3.6.**

COVERED ENTITY:	BUSINESS ASSOCIATE:
Darin J. Gordon	Barbara Anderson
Deputy Commissioner	Vice President
Department of Finance and Adm.	US Government Solutions
Bureau of TennCare	5400 Legacy Drive
310 Great Circle Road	Plano, Texas 75024
Nashville, TN 37243	(972) 605-4136
(615) 507-6443	Fax: (972) 605-9951
Fax: (615) 253-5607	

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

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

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

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

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

IN WITNESS WHEREOF, the Parties execute this Agreement to be valid and enforceable from the last

BUREAU OF TENNCARE	ELECTRONIC DATA SYSTEMS CORP. AND EDS INFORMATION SERVICES, LLC
By: Darin J. Gordon/SH	By: Barbara Anderson
Darin J. Gordon, Deputy Commissioner	Barbara Anderson, Vice President
Date: 6/24/01	Date: 6/22/09
State of Tennessee, Dept of Finance & Adm.	US Government Solutions
310 Great Circle Road	5400 Legacy Drive
Nashville, Tennessee	Plano, TX 75024
(615) 507-6443	(972) 605-4136
Fax: (615) 253-5607	Fax: (972) 605-9951

date set out below:

Attachment D GLOSSARY

Glossary

AAU: Administrative Appeals Unit.

ACCENT: Automated Client Certification Eligibility Network for Tennessee. This Department of Human Services (DHS) information system determines TennCare Standard eligibility for Title XIX individuals and families and forwards this predetermined eligibility to the Bureau.

ACH: Automated Clearing House.

ACWP: Actual Cost of Work Performed.

AD HOC REPORT (AHR): Reports created or used for specific or immediate problems or needs. This also refers to ad hoc notices.

ADA: American Dental Association. The ADA publishes the dental procedure codes (CDT2 and CDT3) used for reporting and billing dental services.

ADA: Americans with Disabilities Act of 1990.

ADAPT: The HCBS waiver program that provides services for seniors in the home setting.

ADJUDICATED CLAIM: A claim that has moved from pending status to final disposition, either paid or denied.

ADJUSTMENT: A debit or credit transaction that corrects a previously paid claim or capitation payment.

AEM: AVAYA Enterprise Manager.

AG: Attorney General of the State of Tennessee.

ALJ: Administrative Law Judge.

AMA: American Medical Association.

ANSI X12: ANSI ASC X12 is an acronym for the American National Standards Institute Accredited Standards Committee (ANSI ASC), which is the national standards body for the development and maintenance of electronic data interchange (EDI) standards for the United States. X12 is a sequential designator assigned by ANSI at the time of accreditation with no other significance. X12 standard transactions and code sets are used in HIPAA standard transactions.

A/P A/R: Accounts Payable and Accounts Receivable.

APD: Advance Planning Document. This is a federal budget request document that a state must submit to CMS in order to receive enhanced federal funding for Medicaid systems or operations.

ARAD: A file sent from DHS of TennCare applicants who never returned to DHS for an interview after filing an application.

ARTS: Appeals Resolution Tracking System.

ARU: Audio response unit.

AS IS: The presently existing condition without modification.

ASCII: American Standard Code for Information Interchange.

ASO: Administrative Service Organization.

AUTOSYS: Software product that centralizes and automates the scheduling and management of jobs in distributed UNIX and Windows NT environments.

AVRS: Automated Voice Response System.

AWP: Average Wholesale Price.

AXIS DIRECT: Mail Vendor used by the Facilities Manager and the Bureau as of the release of the RFP.

BA: Business Services Analyst.

BAA: Business Associate Agreement (in conjunction with HIPAA Privacy and Security Rules).

BCBS: BlueCross BlueShield. BCBST is BlueCross BlueShield of Tennessee.

BCCP: Business Continuity and Contingency Plan.

BCWP: Budgeted Cost of Work Performed.

BCWS: Budgeted Cost of Work Scheduled.

BENDEX: Beneficiary Data Exchange System which is federal government information regarding persons receiving SSA benefits.

BENEFITS: A schedule of covered health care services that an eligible recipient may receive.

BHO: Behavioral Health Organization.

BUREAU: Bureau of TennCare, which may be used interchangeably with the Department of Finance and Administration and State of Tennessee.

BUSINESS ARCHITECTURE: The MITA Business Architecture provides the framework for defining a vision for the next decade for improvements in the Medicaid program operations that result in better outcomes for all stakeholders. The Business Architecture contains models of typical Medicaid business processes and describes how these processes can improve over time. A maturity model is used to show how business capabilities can evolve. States will use the Business Architecture to assess their own current business capabilities and determine future targets for improvement (from CMS Medicaid IT Architecture (MITA) Framework 2.0).

BUSINESS DAY or NORMAL BUSINESS DAY: Monday through Friday from 8:00 a.m. to 5:00 p.m. Central Time, excluding state holidays.

BUY-IN: When states may pay a monthly premium to the Social Security Administration on behalf of eligible Title XIX recipients, enrolling them in the Medicare Title XVIII Part B program.

C & I: Tennessee Department of Commerce and Insurance.

CAP: Corrective Action Plan.

CAPITATION PAYMENT: Monthly payments made to Managed Care Contractors for providing services to TennCare enrollees.

CART: Short for cartridge.

CARVED-OUT SERVICES: A separate group of services that are covered by an unconnected managed care entity (e.g., dental and pharmacy services are “carved out” from the Managed Care Organization’s responsibilities).

CARTRIDGE: A medium for storing data.

CBT: Computer Based Training.

CCB: Change Control Board.

CDT: Central Daylight Time

CERTIFICATION: The MMIS certification process is conducted to verify that a state's TCMIS is working correctly and to validate that the process includes all necessary functionality in order for the state to receive seventy-five percent (75%) Federal Financial Participation (FFP), and to ensure that all legal and operational requirements are met by the MMIS system and its components.

CERTIFICATION DATE: The effective date specified in a written approval notice from CMS to the State when seventy-five percent (75%) FFP is authorized for the administrative costs of an MMIS.

CFR: Code of Federal Regulations.

CHA: Community Health Agencies. Interchangeable with Community Service Agency.

CHAMPUS: Civilian Health and Medical Program of the Uniformed Services.

CHANGE ORDER: A change order is used to define the requested system changes and link together all the development effort documentation.

CHR: Clinical Health Record.

CLAIM: A payment request from a provider for health care services provided to a recipient.

CLAIMS ATTACHMENT: Refers to the federal recommendation for a HIPAA standard transaction to allow payers to request additional information to support claims. The ANSI X12N Healthcare Claim Request for Additional Information (277), the ANSI X12N Additional Information to Support a Healthcare Claim or Encounter (275), and the HL7 Clinical Architecture Document (CDA) were included in the recommendation.

CLAIMS HISTORY: Historically stored claims consisting of all claim types and all subsequent adjustments that have been adjudicated by the iC TCMIS.

CLEAN CLAIM: The term clean claim refers to a claim that does contain a defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

CLIA: Clinical Laboratory Improvement Amendments.

CONTROL MEMORANDUM: Formal contract communiqué that contains the history, background, and any other pertinent information relative to the issue and/or issues being addressed in the Control Memorandum(a). Used to implement contract compliance measures.

CRG: Clinically Related Group.

CMHC: Community Mental Health Centers.

CMM: Capability Maturity Model.

CMMI: Capability Maturity Model Integration.

CMS: Centers for Medicare and Medicaid Services. This is the federal agency (formerly known as HCFA) responsible for the administration of the Medicaid, Medicare, and other health care programs.

CMS-21: Quarterly SCHIP statement of expenditures federal report.

CMS-64: A federal report entitled “Quarterly Medicaid Statement of Expenditures of the Medicaid Program”.

CMS-416: Annual EPSDT federal report.

CMS-1500: The CMS-1500 form is the standard claim form used by a non-institutional provider or supplier to bill Medicare carriers and durable medical equipment regional carriers. It is also used for billing of some Medicaid state agencies.

CMS- 2082: An annual report to CMS that is a required part of the Management and Administrative Reporting Subsystem (MAR).

CMSO: Centers for Medicaid and State Operations.

COB: Coordination of Benefits.

COLD: Computer Output to Laser Disk. This utility is used to access reports stored in the iC TCMIS system.

CONTRACT: The written, signed agreement between the Contractor and the Bureau.

CONTRACT ADMINISTRATOR: State-employed staff person designated to coordinate and monitor the activities of the Contract and to resolve questions and perform other functions as necessary to ensure the Contract is appropriately administered and all terms and conditions of the Contract are met.

CONTRACTING OFFICER: The State official who has overall responsibility for the TCMIS Contract.

CONTRACTOR: The term Contractor refers to an entity with whom the State has successfully negotiated a Contract.

CONTRACTUAL TERMS IN CONTRACT: The use of the terms “shall,” “must,” and “will” refers to a mandatory requirement or condition to be met by the Contractor or by the Bureau. The use of the terms “may” or “should” refer to an optional requirement or condition to be met by the Contractor or by the Bureau.

COTS: Commercial Off-the-Shelf.

CPT: Common Procedural Terminology - A unique coding structure scheme for all medical procedures approved by the American Medical Association.

CPT2, CPT3: Dental procedure codes used for reporting and billing dental services.

CPU: Central Processing Unit.

CROSSOVER CLAIM: The term cross over claim refers to a claim for services rendered to an enrollee eligible for benefits under both Medicaid and Medicare programs. Medicare benefits must be processed prior to Medicaid payment consideration.

CRYSTAL XCELSIUS: A COTS product used to create the Dashboard statistics and reports.

CSA: Community Service Agency. Interchangeable with Community Health Agency.

CSR: Customer Service Representative.

CST: Central Standard Time.

CTS: Computerized Telephony System.

CVO: Centralized Verification Organization.

***DANIELS* LAWSUIT:** See TennCare Lawsuits.

DASHBOARD: Provides reporting of key operational and production metrics.

DBA: Database Administrator.

DBM: Dental Benefits Manager.

DBMS: Database Management System.

DCS: Tennessee Department of Children's Services.

DDI: Design, Development, and Implementation.

DED: Data Element Dictionary.

DEERS: Defense Eligibility and Enrollment Reporting System.

DEPARTMENT: State of Tennessee Department of Finance and Administration, which may be used interchangeably with the State of Tennessee and Bureau of TennCare.

DHCF: Division of Health Care Facilities. This department provides the LTC Unit with "read only Minimum Data Set (MDS)".

DHHS: United States Department of Health and Human Services.

DHS: Tennessee Department of Human Services.

DISABILITY: Condition causing a person to have limited functionality.

DISENROLLMENT: A member is disenrolled or terminated from a Managed Care Contractor (MCC) plan.

DMERC: Durable Medical Equipment Review Contractor.

DMHDD: Tennessee Department of Mental Health and Developmental Disability, used interchangeably with **MHDD.**

DMRS: Tennessee Division of Mental Retardation Services.

DOC: Tennessee Department of Corrections.

DOD: United States Department of Defense.

DOH: Tennessee Department of Health.

DRG: Diagnosis Related Groups. DRGs are used to categorize like type inpatient hospital admissions.

DSD(s): Detailed Systems Design documents.

DSH: Disproportionate Share Hospital.

DSS: Decision Support System. A DSS contains the tools used to extract data from a Data Warehouse.

DUNNING: When an enrollee's premium payments have not been received.

DUPLICATE CLAIM: A claim (or encounter) that is either totally or partially an exact or near duplicate of one (1) previously billed or in process.

DUR: Drug Utilization Review.

EDB: Medicare's Enrollment Data Base.

EDI: Electronic Data Interchange.

EDIFECS: A company that produces a COTS package that performs claims and encounters front-end editing and tracking.

EDISON: An ERP system the State will use to replace STARS, among other things.

EDS: Electronic Data Systems.

EFT: Electronic funds transfer.

EHR: Electronic Health Record.

EMC: Electronic media claims.

ENCOUNTER DATA: Data submitted by Managed Care Contractors for services provided to enrollees.

ENROLLEE: Person participating in the TennCare Program. May be used interchangeably with Member or Recipient.

ENROLLMENT: The process of adding TennCare eligibles to a MCO, BHO, DBM or PBM.

EOB: Explanation of Benefits.

EOP: Explanation of Payment.

EPSDT: Early and Periodic Screening, Diagnosis and Treatment as described in Title XIX of the Social Security Act.

EQRO: External Quality Review Organization.

EQUIPMENT: An article of nonexpendable, tangible, personal property having a useful life of more than one (1) year and an acquisition cost which equals or exceeds five thousand dollars ($5,000.00).

ERP: Enterprise Resource Planning (Edison project).

EVMS: Earned Value Management System.

EVS: Electronic Verification System.

FACILITY MANAGER (FM): The entity contracted by the State to operate, maintain, and enhance a certified TCMIS. Other responsibilities of the Facilities Manager include generating and distributing reports, and performing mailroom operations. Used interchangeably with Facilities Manager and Facilities Management.

FACILITY MANAGEMENT: The act of managing the TCMIS.

F & A: Tennessee Department of Finance and Administration, which may be used interchangeably with the State of Tennessee and Bureau of TennCare.

FCR: Financial change request.

FEDERAL MMIS GSD: Federal Medicaid Management Information System General System Design.

FEIN: Federal Employer Identification Number.

FID: Federal Identification Number.

FFP: Federal Financial Participation.

FFS: Fee-for-service.

FIRM FIXED PRICE: A single price established by the awarding of this Contract not subject to change or negotiation over the term of the Contract.

FISCAL YEAR: The federal fiscal year is October 1st - September 30th. The Tennessee fiscal year is July 1st - June 30th.

FM: Facility Manager.

FMU: Facility Manager Applications/File Maintenance Unit.

FPL: Federal Poverty Level.

FTE: Full time equivalent.

FTP: File Transfer Protocol (Internet).

FQHC: Federally Qualified Health Centers.

GDS: The term GDS refers to general system design, which is the Federal definitive guidelines stating all systems requirements for a certifiable MMIS.

GHI: Group Health Incorporated.

GRIER CONSENT DECREE: Grier Revised Consent Decree (Modified) of Grier v. Goetz. See TennCare Lawsuits.

GUI: Graphical User Interface.

HARDWARE:

1. A computer and the associated physical equipment directly involved in the performance of data-processing or communications functions; and/or

2. Machines and other physical equipment directly involved in performing an industrial, technological function.

HCBS: Home and Community Based Services.

HCFA: Health Care Financing Administration (see CMS).

HCPCS: HCFA Common Procedure Coding System.

HEDIS: Health Plan Employer Data and Information Set.

HHS: U.S. Department of Health and Human Services.

HIC: Health Insurance Claim.

HICN: Health Insurance Control Number (X-reference File)

HIE: Health Information Exchange.

HIPAA: Health Insurance Portability and Accountability Act of 1996, as amended. A federal law that includes requirements to protect patient privacy, protect security and data integrity of electronic medical records, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers.

HIPAA STANDARD TRANSACTIONS:

NCPDP 1.1: NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), supporting Telecommunication Standard Implementation Guide, Version 5, Release 1 (Version 5.1) for the NCPDP Data Record in the Detail Data Record.

NCPDP 5.1: NCPDP Telecommunication Standard Implementation Guide Version 5, Release 1 (Version 5.1).

X12 270: Health Care Eligibility Benefit Inquiry EDI transaction.

X12 271: Health Care Eligibility Benefit Response EDI transaction.

X12 276: Health Care Claim Status Request EDI transaction.

X12 277: Health Care Claim Status Response EDI transaction, will also be the Health Care Claim Request for Additional Information in the Claims Attachment EDI transaction (but will be a different IG).

X12 278: Health Care Services Review – Request for Review and Response EDI transaction (Prior Authorization).

X12 820: Payroll Deducted and Other Group Premium Payment for Insurance Products EDI transaction.

X12 834: Benefit Enrollment & Maintenance EDI transaction.

X12 835: Health Care Claim Payment/Advice EDI transaction.

X12 837I: Health Care Claim- Institutional EDI transaction.

X12 837P: Health Care Claim- Professional EDI transaction.

X12 837D: Health Care Claim- Dental EDI transaction.

HIPP: Health Insurance Purchasing Program.

HMS: Health Management System, the Bureau TPL contractor.

HW/SW: Hardware/Software.

IC: interChange.

ICD-9-CM/ICD-10-CM: International Classification of Diseases, 9th Edition, Clinical Modification; ICD-10-CM (10th Edition), when published, will replace the current ICD-9-CM classification of disease manual.

ICF: Intermediate Care Facility.

ICF/MR: Intermediate Care Facility/Mental Retardation: An intermediate care facility providing health and mental health care and services to mentally retarded or developmentally disabled individuals who do not require hospitalization.

ICN: The ICN is an internal control number that is a unique thirteen-digit control number assigned to each claim. The format for the ICN is: YJJJMBBSSSLL

Y = year

J = Julian date

M = media code

B = batch number

S = sequence within batch

L = line number

IEEE: Industrial Electrical and Electronic Engineers.

IM: Information Management.

INSTITUTION(S): An establishment that provides care for enrollees (e.g., long term care, skilled nursing, mental health).

INTERCHANGE: The EDS system to support TCMIS operations.

IO: Input/Output.

IS: Information Systems.

ISDM: Information Systems Development Methodology.

ISO: International Standard Organization.

IT: Information Technology.

ITM: The State's Information Technology Methodology.

IV-D: Title IV, Part D of Social Security Act (Child Support and Establishment of Paternity).

IV&V: Independent Verification and Validation.

IVR: Integrated Voice Response.

JAD: Joint Application Design - a method for defining and designing the requirements for the TCMIS.

JAR: Joint Application Requirements - a method for reviewing and modifying or designing the requirements for the TCMIS.

JCL: Job Control Language.

JOINT VENTURE: An endeavor by two or more entities who have combined resources or products.

JUDICIAL: A category of eligibility whereby the enrollee is only entitled to receive behavioral health services/evaluations as ordered by a court.

LAN: Local Area Network.

LSU: Bureau of TennCare Legal Solutions Unit.

LTC: Long Term Care.

MAC: Maximum Allowable Cost.

MAR: Management and Administrative Reporting.

MCC: Managed Care Contractors. This term is inclusive of all Managed Care Organizations (MCOs), Behavioral Health Organizations (BHOs), Pharmacy Benefits Manager (PBM), Dental Benefits Manager (DBM) and Administrative Service Organization (ASO) contracted with the State.

MCKESSON: A company that produces a COTS package that performs claims rule and data validation.

MCO: Managed Care Organization.

ME: Medical Eligibility.

MEDICAID: See Title XIX.

MEDICALLY NEEDY: Those recipients who meet Medicaid eligibility criteria but whose income and resources are above the limits prescribed for the categorically needy and are within the limits set under the Tennessee Medicaid plan.

MEDICARE: See Title XVIII.

MEDICARE CROSSOVER: Same as a crossover claim.

MEMBER: An individual enrolled in the TennCare Program. May be used interchangeably with Recipient or Enrollee.

MEQC: Medicaid Eligibility Quality Control.

MEU: Medical Evaluation Unit.

MFCU: Medicaid Fraud Control Unit.

MHDD: Tennessee Department of Mental Health and Developmental Disability, used interchangeably with DMHDD.

MITA: Medicaid Information Technology Architecture.

MMA: Medicare Modernization Act.

MMIS: Medicaid Management Information System.

MR: Mental Retardation - often used in conjunction with MHDD.

MR/DD: Mental Retardation/Developmental Disabilities.

MSIS: Medicaid Statistical Information System.

NAIC: National Association of Insurance Commissioners.

NASCIO: National Association of State Chief of Information Officers.

NCPDP: National Council for Prescription Drug Programs.

NCQA: National Committee on Quality Assurance.

NDC: National Drug Code.

NF: Nursing Facility.

NH: Nursing Home.

NIST: National Institute of Standards and Technology.

NOSC: Network Operations and Security Center.

NPI: National Provider Identifier.

OATS: Online Application Tracking System. A file used by TennCare and DHS for recipients who have applied for eligibility

OBRA '90: Omnibus Budget Reconciliation Act - 1990.

OCCP: Bureau of TennCare Office of Contract Compliance and Performance.

OCR: Tennessee Department of Finance and Administration - Office of Contract Review.

OCR: Optical Character Recognition.

OGC: Bureau of TennCare Office of General Counsel.

OIG: Bureau of TennCare Office of Inspector General.

OIR: The Office for Information Resources (OIR), a division within the Tennessee Department of Finance and Administration, is responsible for the State's centralized data processing and hosts the TCMIS at its facilities in Nashville, Tennessee. The OIR is responsible for disaster recovery and ensuring a "hot site" is available, if needed.

ONLINE: Using a computer to have immediate access to stored data.

ORACLE: A COTS software package used by the Bureau of TennCare for financials and reporting financials.

ORR: On Request Report.

OS: Operating System.

OSCAR: Online Survey, Certification and Reporting Interface.

P & T: Pharmacy and Therapeutics.

PACE: Program of All-inclusive Care for the Elderly, an elderly and disabled HCBS waiver program.

PAE: Preadmission Evaluation, an application for individuals seeking Medicaid reimbursement of nursing home care, Home and Community Based Services (HCBS) in a waiver program, and PACE services.

PAQ: Project Assessment Quotation.

PARIS: Public Assistance Reporting Information System.

PART D: Prescription drug program under the Federal Medicare Modernization Act (MMA).

PARTNERING ENTITIES: Two or more contractors or business associates combining their services or products to form a joint venture.

PASRR: Pre-Admission Screening and Resident Review.

PBM: Pharmacy Benefits Manager.

PC: Personal Computer.

PCCM: Primary Care Case Management program.

PCG: Public Consulting Group, previous TPL contractor.

PCP: Primary Care Provider.

PDF: Portable Document Format (Adobe Acrobat).

PDS: Premise Distribution System.

PM: Project Manager.

PMBOK: Project Management Body of Knowledge.

PMI: Project Management Institute.

PMO: Project Management Office.

PMP: Project Management Professional certified by the PMI.

PMPM: Per Member per Month.

POS: Point of Sale.

PQAS: Prior Quarter Adjustment Statement (drug rebate electronic interface).

PREMIUM: Refers to the amount owed by TennCare enrollees who are over one hundred percent (100%) of the Federal Poverty Level and are considered uninsured or uninsurable.

PRO: Peer Review Organization.

PROCUREMENT LIBRARY: TCMIS items for review by RFP Proposers.

PRODUR: Prospective Drug Utilization Review.

PROGRAMMER: Refers to a person who designs, writes, and tests computer programs. In reference to this Contract, a person with a minimum of two (2) years of experience in systems development and maintenance with training in the technologies used in MMIS systems.

PROLAW: The software system used to track all documentation and information related to a particular medical or reimbursement appeal and its status.

PROVIDER: Entity that provides services (e.g., medical, mental health, dental, or pharmacy).

PWB: Project Work Book.

PWP: Project Work Plan.

QI: Quality improvement.

QM: Quality Management.

QUALITY MANAGEMENT PLAN: Plan submitted by the Contractor to the Bureau describing how quality will be maintained.

QMB: Qualified Medicare Beneficiary.

RA or R/A: Remittance Advice, a document sent to providers to explain the payment, nonpayment, return or status of pended claims.

RACF: Refers to the State of Tennessee's Security System.

RBRVS: Resource Based Relative Value Scale.

RC: Release Coordinator.

RDBMS: Relational Database Management System.

RECIPIENT: An individual enrolled in the TennCare Program. May be used interchangeably with Enrollee or Member.

RECONSIDERATION CLAIMS: The process by which a MCC or the Bureau reviews and renders a decision regarding an enrollee's appeal for the MCCs adverse action affecting TennCare benefits. This may include the reconsideration claims, including, but not limited to, traditional reconsiderations (e.g., appeals) and the following: late billing, enrollee retroactive eligibility, out-of-state emergency, payment under court order, result of an appeal/fair hearing, class action suit, and any other Bureau-defined situation, in accordance with Bureau instructions.

REMITTANCE ADVICE: Document used by Medicaid agencies to reports claims payments or reasons that claims were denied or rejected, either proprietary or X12 835.

REOMB: Recipient Explanation of Medicaid Benefits.

RESOURCE LEVEL STAFFING PLAN: Listing of key staff and the corresponding job description

RETRODUR: Retrospective Drug Utilization Review.

RETURNED CLAIM: A claim which contains errors such as missing data, incorrect entries on the claim form, or conflicting information, and that is returned to the provider without being adjudicated.

REVENUE CODE: A three (3) digit code used to identify and bill for services on a UB92 claim form.

RID: Recipient Identification Number.

RIDMATCH: A process for matching Recipient Identification (RID) numbers of Medicaid recipients whose eligibility had been extended (by the iC monthly extend process), against a daily file received from DHS to process updates for which responses have been received

RFP: Request for Proposals.

RMHI: Regional Mental Health Institutes.

***ROSEN*:** See TennCare Lawsuits.

ROSI: Reconciliation of State Invoices.

RRI: Recognition Research Imaging. The forms processing solution used by the Facilities Manager to automate data capture (e.g. scanned claims and attachments).

RTE: Return to Enrollee, this term is only applicable for Medical Eligibility (ME) functions.

RTP: Return to provider.

SAK: System Assigned Key.

SAS-70: Statement on Auditing Standards (Service Organizations)

SCAMPI: Standard CMMI Appraisal Method for Process Improvement.

SCANSTATION: A system to scan documents and correspondence.

SCR: System Change Request – a modification/enhancement request for the TCMIS.

SCCS: Source Code Control System.

SDLC: Systems Development Life Cycle.

SDX: State Data Exchange.

SDS: System Development and Support.

SE: Information Analyst/Programmer Analyst/Systems Engineer.

SED: Seriously Emotionally Disturbed enrollees. This designation is for children only.

SEI: Software Engineering Institute.

SHP TIS: State Health Plan/Tennessee Insurance System, a TPL interface.

SLA: Service Level Agreement, a part of the Enterprise Service Bus (ESB).

SLMB: Special Low-Income Medicare Beneficiary.

SINGLE STATE AGENCY: The department of a state that is legally authorized and responsible for the statewide administering of the state's plan for medical assistance. The Tennessee Department of Finance and Administration, Bureau of TennCare is the designated Single State Agency in Tennessee.

SMD: State Medicaid Director.

SMM: State Medicaid Manual.

SME: Subject matter expert.

SMM: State Medicaid Manual.

SNF: Skilled Nursing Facility. A skilled nursing facility is also referred to as NF Level Two.

SOFTWARE: The programs, routines, and symbolic languages that control the functioning of the hardware and direct its operation.

SOLQ: Social Security Online Query file.

SPMI: Severely and Persistently Mentally Ill enrollees. This designation is for adults only.

SPR: Federal Systems Performance Review, which is an annual review of the MMIS performed by CMS to ensure that the system continues to meet all stated requirements.

SPRS: Service Provider Registry System.

SQL: Structured Query Language.

SSA: United States Social Security Administration.

SSI: Supplemental Security (Disability) Income for the aged, blind, and disabled.

SSN: Social Security Number.

STAKEHOLDER: An individual or group with an interest in the success of a group or an organization in delivering intended results and maintaining the viability of the group or organization's product and/or service. Stakeholders influence programs, products, and services.

STARS: State Accounting and Reporting System.

STATE: The State of Tennessee, which may be used interchangeably with the Department of Finance and Administration and Bureau of TennCare.

STATE ONLY: A category of eligibility whereby the enrollee is only entitled to receive behavioral health services as approved by the Department of Mental Health.

SUBCONTRACTOR: A party contracting with the Contractor and approved by the Bureau to perform services for the Bureau.

SUR: Surveillance and Utilization Review.

SURS: Surveillance and Utilization Review Subsystem.

TAD: Turnaround Document. Long term care Level One nursing facilities as well as HCBS and PACE (TennCare portion of capitation payments) provider services are currently billed to TennCare via this method.

TBI: Tennessee Bureau of Investigation.

TC: TennCare.

TCA: Tennessee Commission on Aging.

T.C.A.: Tennessee Code Annotated.

TCIS: TennCare Information Systems, referenced as an entity of the Bureau's management of the TCMIS.

TCMIS: TennCare Management Information System.

TDHS: Tennessee Department of Human Services, also referred to as DHS.

TDM: Technical Delivery Manager.

TDMR: Tennessee Division of Mental Retardation Services.

TDTM: Technical Delivery Team Manager.

TEMA: Tennessee Emergency Management Agency.

TEAMTRACK: Bureau of TennCare Change Management tracking software (Serena®TeamTrack®).

TENNCARE: Tennessee Medicaid program under a 1115 waiver to the Social Security Act.

TENNCARE LAWSUITS: There are three (3) primary, federal class action lawsuits that have a direct impact on the business rules and operations of the TennCare Program. The lawsuits are:

DANIELS - this lawsuit was filed against the State in 1979 for noncompliance with Medicaid laws and regulations relating to due process and appeal rights of persons on Medicaid. Current State rules provide for an enrollee's appeal and hearing rights when services are denied, delayed, terminated, reduced or suspended, as well as for the enrollee's entitlement to a written decision on appeal within ninety (90) days for a standard appeal or thirty-one (31) days for an expedited appeal. It requires that an annual letter be sent to all TennCare enrollee's advising them of their appeal rights.

GRIER - is a 1999 federal class action lawsuit, resulting from the Daniels lawsuit. The consent decree expands the definition of what an enrollee can appeal. An enrollee may appeal an "adverse action" which is a denial, delay, termination, reduction or suspension of a TennCare benefit or any other act or omission that impairs the quality or timeliness of such benefit. A doctor's prescription is no longer needed to appeal. The consent decree provides for a fourteen (14) day supply of drugs and prohibits the Bureau of TennCare from terminating eligibility except for enrollees known to be living out-of-state or due to death.

ROSEN - this case was filed on behalf of persons eligible for TennCare as part of the expansion population in 1998, challenging the State's policies and procedures for determining and terminating TennCare eligibility. The major issue in the lawsuit was whether applicants and enrollees received appropriate due process, including the right to a hearing in such determinations.

TITLE XVI: Civil Rights Act of 1964.

TITLE XVIII: Medicare health insurance component of the Social Security Act covering hospitalization (Part A) and medical (Part B).

TITLE XIX: The medical federal assistance program (Medicaid) as described in Title XIX of the Social Security Act.

TN KIDS: System maintained by DCS that is used to derive the DCS files.

TO-BE: The desired level of MITA.

TPL: Third Party Liability.

TPW: Tennessee Prison for Women.

TSU: Bureau of TennCare TennCare Solutions Unit for appeals and grievances.

TTS: Text-To-Speech Server used in AVRS.

TRANSLATOR: An application program designed to convert one (1) electronic format, in particular the HIPAA X12N standard transactions, into another format and perform additional data conversion if desired. TCMIS uses Sybase.

TWISS: Tennessee Welfare Integrated Services System.

UAT: User Acceptance Testing.

UCR: Usual and Customary and Reasonable rates.

UML: Unified Modeling Language

UPIN: Universal Provider Identification Number.

UPS: Uninterruptible Power Source.

U.S.C.A.: United States Code Annotated.

VA: United States Veteran's Administration.

VCTL: Version Control.

VENDOR: Any responsible source that provides a supply or service.

VIP: Vision Integration Platform, new Tennessee DHS eligibility system.

VPN: Virtual Private Network.

WAN: Wide area network.

WBS: Work Breakdown Structure.

WBT: Web Based Training.

WEDI SNIP: Workgroup for Electronic Data Interchange Strategic National Implementation Process.

WORK PLAN: Document identifying the tasks to be performed and the timeline for each task

WP: Work Planner.

WR: Work Request - A maintenance request for the TCMIS, a non-billable function.

WORK REQUEST: A maintenance request for the TCMIS, a non-billable function.

WORKING DAY: State workday. A "day" is defined as a minimum of eight (8) hours of service.

W3C: World Wide Web Consortium.

X12: An ANSI-accredited group that defines EDI standards for many American industries, including health care insurance. Most of the electronic transaction standards proposed under HIPAA are X12 standards.

X12 997: Functional Acknowledgement EDI transaction.

XML: Extensible Markup Language.

1610: Eligibility format from DHS.

Attachment E Performance Bond

PERFORMANCE BOND

The Surety Company issuing bond shall be licensed to transact business in the State of Tennessee by the Tennessee Department of Commerce and Insurance. Bonds shall be certified and current Power-of-Attorney for the Surety's Attorney-in-Fact attached.

KNOW ALL BY THESE PRESENTS:

That we,

_____

(Name of Principal)

_____

(Address of Principal)

as Principal, hereinafter called the Principal, and

_____

(Name of Surety)

_____

(Address of Surety)

as Surety, hereinafter call the Surety, do hereby acknowledge ourselves indebted and securely bound and held unto the State of Tennessee as Obligee, hereinafter called the Obligee, and in the penal sum of Ten Million Dollars ($10,000,000.00), good and lawful money of the United States of America, for the use and benefit of those entitled thereto, for the payment of which, well and truly to be made, we bind ourselves, our heirs, our administrators, executors, successors, and assigns, jointly and severally, firmly by these presents.

BUT THE CONDITION OF THE FOREGOING OBLIGATION OR BOND IS THIS:

WHEREAS, the Obligee has engaged the Principal for a sum not to exceed Contract Maximum Liability:

One Million Seventy Million Six Hundred Sixty Two Thousand Fifty-Four Dollars ($170,662,054.00) to complete the work detailed in the contract Scope of Services.

_____

NOW, THEREFORE, if the Principal shall fully and faithfully perform all undertakings and obligations under the Contract hereinbefore referred to and shall fully indemnify and hold harmless the Obligee from all costs and damage whatsoever which it may suffer by reason of any failure on the part of the Principal to do so, and shall fully reimburse and repay the Obligee any and all outlay and expense which it may incur in making good any such default, and shall fully pay for all of the labor, material, and Work used by the Principal and any immediate or remote sub-contractor or furnisher of material under the Principal in the performance of said Contract, in lawful money of the United States of America, as the same shall become due, then this obligation or bond shall be null and void, otherwise to remain in full force and effect.

AND for value received, it is hereby stipulated and agreed that no change, extension of time, alteration, or addition to the terms of the Contract or the Work to be performed there under or the specifications accompanying the same shall in any wise affect the obligation under this bond, and notice is hereby waived of any such change, extension of time, alteration, or addition to the terms of the Contract or the Work or the specifications.

PROVIDED, HOWEVER, that in no event shall the surety's liability exceed the penal sum of this bond.

IN WITNESS WHEREOF the Principal has hereunto affixed its signature and Surety has hereunto caused to be affixed its corporate signature and seal, by its duly authorized officers, on this

_____ day of _____ , _____ .

WITNESS:

_____	_____
(Name of Principal)	(Name of Surety)
_____	_____
(Authorized Signature of Principal)	(Signature of Attorney-in-Fact)
_____	_____
(Name of Signatory)	(Name of Attorney-in-Fact)
_____	_____
(Title of Signatory)	(Tennessee License Number of Surety)