STATE OF TENNESSEE

DEPARTMENT OF FINANCE AND ADMINISTRATION

BUREAU OF TENNCARE

REQUEST FOR PROPOSALS

FOR

REPROCUREMENT OF TENNCARE MANAGEMENT INFORMATION SYSTEM (TCMIS)

RFP NUMBER: 318.65-211

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1. INTRODUCTION

1.1. STATEMENT OF PURPOSE

The State of Tennessee, Department of Finance and Administration, Bureau of TennCare, hereinafter referred to as the State or the Bureau, has issued this Request for Proposals (RFP) to define the State's minimum service requirements; solicit proposals; detail proposal requirements; and, outline the State's process for evaluating proposals and selecting the contractor.

Through this RFP, the State seeks to buy the best services at the most favorable, competitive prices and to give ALL qualified businesses, including those that are owned by minorities, women, and persons with a disability, and small business enterprises, opportunity to do business with the state as contractors and sub-contractors.

The State intends to secure a Contract for a Facilities Manager to takeover the current TennCare Management Information System (TCMIS), as well as to incorporate several enhancements. The Facilities Manager will operate, maintain, and enhance the TCMIS to efficiently meet the business requirements of the Bureau of TennCare, its stakeholders, enrollees, and business partners.

The successful completion of the Reprocurement of TennCare Management Information System (TCMIS) will result in the following benefits to the Bureau of TennCare:

- Bureau of TennCare staff will have more convenient and timely access to system information, procedure manuals, and enrollee and provider data,
- Authorized users will have online access to critical documents as defined and requested by the Bureau,
- Claims/Encounter Claims editing will be improved through the use of a new COTS software package,
- Creation of a Project Management Office and establishing well-defined Change Order Processes will lead to greater cooperation between the Bureau and Contractor, resulting in more successful TCMIS maintenance and modifications.
- Performance Measures will define the Bureau's expectations and create limits of accountability for the Contractor by performance measures and benchmarks that must be met.
- Better strategy to approach and implement future initiatives.
- Contractor responsiveness to Bureau requests will improve.

In preparing proposals in response to this RFP, Proposers are encouraged to access information provided in the Project Work Book (PWB) and in the State's Procurement Library. Proposers may find additional information in the Procurement Library that will be beneficial in the preparation of their proposals. RFP Attachment 6.9 lists the contents of the Procurement Library.

1.2. SCOPE OF SERVICE, CONTRACT PERIOD, AND REQUIRED TERMS AND CONDITIONS

1.2.1. Scope of Service

The RFP Section 6.1 *Pro Forma* Contract details the State's required:

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

The *Pro Forma* Contract substantially represents the State's Contract document in which the Proposer selected by the State MUST agree to and sign.

1.3. NONDISCRIMINATION

No person shall be excluded from participation in, be denied benefits of, be discriminated against in the admission or access to, or be discriminated against in treatment or employment in the State's contracted programs or activities on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by federal or Tennessee State Constitutional or statutory law; nor shall they be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of contracts with the State or in the employment practices of the State's contractors. Accordingly, all vendors entering into contracts with the State shall, upon request, be required to show proof of such nondiscrimination and to post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

The State has designated the following to coordinate compliance with the nondiscrimination requirements of the State of Tennessee, Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, and applicable federal regulations.

Helen Moore

Bureau of TennCare

310 Great Circle Road
Nashville, TN 37243
(615) 507-6474 (Phone)

1.4. ASSISTANCE TO PROPOSERS WITH A DISABILITY

A Proposer with a disability may receive accommodation regarding the means of communicating this RFP and participating in this RFP process. A Proposer with a disability should contact the RFP Coordinator to request reasonable accommodation no later than the Disability Accommodation Request Deadline detailed in the RFP Section 2, Schedule of Events.

1.5. RFP COMMUNICATIONS

1.5.1 **Unauthorized contact regarding this RFP with employees or officials of the State of Tennessee other than the RFP Coordinator detailed below may result in disqualification from this procurement process.**

1.5.1.1 Interested Parties must direct all communications regarding this RFP to the following RFP Coordinator, who is the State of Tennessee's only official point of contact for this RFP.

Alma Chilton
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243
(615) 507-6384 (Phone)
(615) 253-5414 (Fax)
-e-mail: Alma.Chilton@state.tn.us

1.5.1.2 Notwithstanding the foregoing, Interested Parties may contact the staff of the Governor's Office of Diversity Business Enterprise for general, public information regarding this RFP, assistance available from the Governor's Office of Diversity Business Enterprise, or potential future state procurements.

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

RFP-318.65-211

1.5.3 Any oral communications shall be considered unofficial and non-binding with regard to this RFP.

1.5.4 Each Proposer shall assume the risk of the method of dispatching any communication or proposal to the State. The State assumes no responsibility for delays or delivery failures resulting from the method of dispatch. Actual or electronic "postmarking" of a communication or proposal to the State by a deadline date shall not substitute for actual receipt of a communication or proposal by the State.

1.5.5 The RFP Coordinator must receive all written comments, including questions and requests for clarification, no later than the Written Comments Deadline detailed in the RFP Section 2, Schedule of Events.

1.5.6 The State reserves the right to determine, at its sole discretion, the appropriate and adequate responses to written comments, questions, and requests for clarification. The State's official responses and other official communications pursuant to this RFP shall constitute an amendment of this RFP.

1.5.7 The State will convey all official responses and communications pursuant to this RFP to the potential Proposers from whom the State has received a Notice of Intent to Propose.

1.5.8 Only the State's official, written responses and communications shall be considered binding with regard to this RFP.

1.5.9 The State reserves the right to determine, at its sole discretion, the method of conveying official responses and communications pursuant to this RFP (e.g. written, facsimile, electronic mail, or Internet posting). Most important documents will be posted on the following website:

http://state.tn.us/finance/oir/pcm/rfps.html

1.5.10 Any data or factual information provided by the State, in this RFP or an official response or communication, shall be deemed for informational purposes only, and if a Proposer relies on such data or factual information, the Proposer should either: (1) independently verify the information; or, (2) obtain the State's written consent to rely thereon.

1.6. NOTICE OF INTENT TO PROPOSE

Each potential Proposer should submit a Notice of Intent to Propose to the RFP Coordinator by the deadline detailed in the RFP Section 2, Schedule of Events. The notice should include:

- Proposer's name
- Name and title of a contact person
- Address, telephone number, and facsimile number of the contact person

NOTICE: A Notice of Intent to Propose creates no obligation and is not a prerequisite for making a proposal. However, it is necessary to ensure receipt of RFP amendments and other communications regarding the RFP (refer to RFP Sections 1.5, et seq., above).

Additionally, the organizations that submit a Notice of Intent to Propose will receive a DVD with many of the documents from the Procurement Library resource, and a copy of the TCMIS core system source code.

1.7. PROPOSAL DEADLINE

Proposals must be submitted no later than the Proposal Deadline time and date detailed in the RFP Section 2, Schedule of Events. A proposal must respond to the written RFP and any RFP exhibits, attachments, or amendments. A late proposal shall not be accepted, and a Proposer's failure to submit a Proposal before the deadline shall cause the proposal to be disqualified.

1.8. PRE-PROPOSAL CONFERENCE

A Pre-Proposal Conference will be held at the time and date detailed in the RFP Section 2, Schedule of Events. The purpose of the conference is to discuss the RFP scope of services. While questions will be entertained, the response to any question at the Pre-Proposal Conference shall be considered tentative and non-binding with regard to this RFP. Questions concerning the RFP should be submitted in writing prior to the Written Comments Deadline date detailed in the RFP Section 2, Schedule of Events. To ensure accurate, consistent responses to all known potential Proposers, the official response to questions will be issued by the State as described in RFP Sections 1.5, et seq., above and on the date detailed in the RFP Section 2, Schedule of Events.

Pre-Proposal Conference attendance is not mandatory, and each potential Proposer may be limited to a maximum number of attendees depending upon overall attendance and space limitations. The conference will be held at:

310 Great Circle Road
Nashville, TN 37243

1.9. PERFORMANCE BOND

The State shall require a performance bond upon approval of a Contract pursuant to this RFP. The amount of the performance bond must be in the sum of ten million dollars ($10,000,000).

The successful Proposer shall obtain the required performance bond in form and substance acceptable to the State (refer to RFP Attachment 6.6) and provide it to the State no later than the immediately preceding the Contract start date detailed in the RFP Section 2, Schedule of Events, and as may be amended.

The successful Proposer must meet this performance bond requirement either by providing the State (as required) a performance bond that covers the entire Contract period including all options to extend the Contract, or by providing a performance bond for the first, annual period 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 annual (or re-issued) performance bond in the amount of ten million dollars ($10,000,000) covering each subsequent annual period of the Contract. The Contractor must provide annual (or re-issued) performance bonds to the State no later than December 10th preceding the annual covered period beginning on January 1st of each year.

Failure to provide to the State the performance bond in the amount of ten million dollars ($10,000,000) as required prior to the Contract start date and, as applicable in the case of an annual performance bond, no later than December 10th preceding each annual covered period beginning on January 1st each year, shall result in contract termination.

The successful Proposer shall make all necessary arrangements for the performance bond prior to the Contract start date and prior to any subsequent performance bond deadlines in the case of an annual performance bond. The State will not assist the Proposer securing the services of any fidelity or guaranty underwriter.

Failure to adhere to the requirements of this RFP Section 1.9 shall result in termination of the Contract as a material breach of the contract.

2. RFP SCHEDULE OF EVENTS

The following Schedule of Events represents the State's best estimate of the schedule that will be followed. Unless otherwise specified, the time of day for the following events will be between 8:00 a.m. and 4:30 p.m., Central Standard Time.

RFP SCHEDULE OF EVENTS

NOTICE: The State reserves the right, at its sole discretion, to adjust this schedule as it deems necessary. The State will communicate any adjustment to the Schedule of Events to the potential Proposers from whom the State has received a Notice of Intent to Propose.

EVENT	TIME	DATE (all dates are State business days)
1. State Issues RFP		9/12/2007
2. Disability Accommodation Request Deadline		9/19/2007
3. Pre-proposal Conference	1:00 p.m. CDT	9/21/2007
4. Notice of Intent to Propose Deadline		9/25/2007
5. Written Comments Deadline		10/1/2007
6. State Responds to Written Comments		10/22/2007
7. Proposal Deadline	2:00 p.m. CST	12/3/2007
8. State Completes Technical Proposal Evaluations		12/17/2007
9. State Opens Cost Proposals and Calculates Scores	9:00 a.m. CST	12/18/2007
10. State Issues Evaluation Notice and Opens RFP Files for Public Inspection	9:00 a.m. CST	12/19/2007
11. Contract Signing		1/2/2008
12. Contract Signature Deadline		1/9/2008
13. Performance Bond Deadline		1/10/2008
14. Contract Start Date		1/11/2008

3. PROPOSAL REQUIREMENTS

Each Proposer must submit a proposal in response to this RFP with the most favorable terms that the Proposer can offer. There will be no best and final offer procedure.

3.1. PROPOSAL FORM AND DELIVERY

3.1.1 Each response to this RFP must consist of a Technical Proposal and a Cost Proposal (as described below).

3.1.2 Each Proposer must submit one (1) original and eight (8) copies, plus three (3) electronic copies in PDF format on CD or DVD, of the Technical Proposal to the State in a sealed package that is clearly marked:

"Technical Proposal in Response to 318.65-211 -- Do Not Open"

3.1.3 Each Proposer must submit one (1) Cost Proposal to the State in a separate, sealed package that is clearly marked:

"Cost Proposal in Response to 318.65-211 -- Do Not Open"

3.1.4 If a Proposer encloses the separately sealed proposals (as detailed above) in a larger package for mailing, the Proposer must clearly mark the outermost package:

"Contains Separately Sealed Technical and Cost Proposals for 318.65-211"

3.1.5 The State must receive all proposals in response to this RFP, at the following address, no later than the Proposal Deadline time and date detailed in the RFP Section 2, Schedule of Events.

Alma Chilton
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243
(615) 507-6384 (Phone)
(615) 253-5414 (Fax)
e-mail: Alma.Chilton@state.tn.us

3.1.6 A Proposer may not deliver a proposal orally or by any means of electronic transmission.

3.2. TECHNICAL PROPOSAL

3.2.1 The RFP Attachment 6.3, Technical Proposal and Evaluation Guide details specific requirements for making a Technical Proposal in response to this RFP. This guide includes mandatory and general requirements as well as technical queries requiring a written response.

NOTICE: No pricing information shall be included in the Technical Proposal. Inclusion of Cost Proposal amounts in the Technical Proposal shall make the proposal non-responsive and the State shall reject it.

3.2.2 Each Proposer must use the Technical Proposal and Evaluation Guide to organize, reference, and draft the Technical Proposal. Each Proposer should duplicate the Technical Proposal and Evaluation Guide and use it as a table of contents covering the Technical Proposal (adding proposal page numbers as appropriate).

3.2.3 Each proposal should be economically prepared, with emphasis on completeness and clarity of content. A proposal, as well as any reference material presented, must be written in English and must be written on standard 8 1/2" x 11" paper (although foldouts

containing charts, spreadsheets, and oversize exhibits are permissible). All proposal pages must be numbered.

3.2.4 All information included in a Technical Proposal should be relevant to a specific requirement detailed in the Technical Proposal and Evaluation Guide. All information must be incorporated into a response to a specific requirement and clearly referenced. Any information not meeting these criteria will be deemed extraneous and will in no way contribute to the evaluation process

3.2.5 The State may determine a proposal to be non-responsive and reject it if the Proposer fails to organize and properly reference the Technical Proposal as required by this RFP and the Technical Proposal and Evaluation Guide.

3.2.6 The State may determine a proposal to be non-responsive and reject it if the Technical Proposal document fails to appropriately address/meet all of the requirements detailed in the Technical Proposal and Evaluation Guide.

3.3. COST PROPOSAL

3.3.1 The Cost Proposal must be submitted to the State in a sealed package separate from the Technical proposal.

3.3.2 Each Cost Proposal must be recorded on an exact duplicate of the RFP Attachment 6.4, Cost Proposal and Scoring Guide.

3.3.3 Each Proposer shall ONLY record the proposed cost exactly as required by the Cost Proposal and Scoring Guide and shall NOT record any other rates, amounts, or information.

3.3.4 The proposed cost shall incorporate all costs for services under the Contract for the total contract period.

3.3.5 The Proposer must sign and date the Cost Proposal.

3.3.6 If a Proposer fails to submit a Cost Proposal as required, the State shall determine the proposal to be non-responsive and reject it.

4. GENERAL REQUIREMENTS AND CONTRACTING INFORMATION

4.1. PROPOSER REQUIRED REVIEW AND WAIVER OF OBJECTIONS

Each Proposer must carefully review this RFP and all attachments, including but not limited to the *Pro Forma* Contract, for comments, questions, defects, objections, or any other matter requiring clarification or correction (collectively called "comments"). Comments concerning RFP objections must be made in writing and received by the State no later than the Written Comments Deadline detailed in the RFP Section 2, Schedule of Events. This will allow issuance of any necessary amendments and help prevent the opening of defective proposals upon which Contract award could not be made.

Protests based on any objection shall be considered waived and invalid if these comments/objections have not been brought to the attention of the State, in writing, by the Written Comments Deadline.

4.2. RFP AMENDMENT AND CANCELLATION

The State reserves the unilateral right to amend this RFP in writing at any time. If an RFP amendment is issued, the State will convey such amendment to the potential Proposers who submitted a Notice of Intent to Propose. Each proposal must respond to the final written RFP and any exhibits, attachments, and amendments.

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

4.3. PROPOSAL PROHIBITIONS AND RIGHT OF REJECTION

4.3.1 The State of Tennessee reserves the right, at its sole discretion, to reject any and all proposals in accordance with applicable laws and regulations.

4.3.2 Each proposal must comply with all of the terms of this RFP and all applicable State laws and regulations. The State may reject any proposal that does not comply with all of the terms, conditions, and performance requirements of this RFP. The State may consider any proposal that does not meet the requirements of this RFP to be non-responsive, and the State may reject such a proposal.

4.3.3 A proposal of alternate services (e.g. a proposal that offers services different from those requested by this RFP) shall be considered non-responsive and rejected.

4.3.4 A Proposer may not restrict the rights of the State or otherwise qualify a proposal. The State may determine such a proposal to be a non-responsive counteroffer, and the proposal may be rejected.

4.3.5 A Proposer may not submit the Proposer's own Contract terms and conditions in a response to this RFP. If a proposal contains such terms and conditions, the State may determine, at its sole discretion, the proposal to be a non-responsive counteroffer, and the proposal may be rejected.

4.3.6 A Proposer shall not submit more than one (1) proposal. Submitting more than one (1) proposal shall result in the disqualification of the Proposer.

4.3.7 A Proposer shall not submit multiple proposals in different forms. This prohibited action shall be defined as a Proposer submitting one (1) proposal as a prime Contractor and permitting a second Proposer to submit another proposal with the first Proposer offered

as a subcontractor. This restriction does not prohibit different Proposers from offering the same subcontractor as a part of their proposals, provided that the subcontractor does not also submit a proposal as a prime Contractor. Submitting multiple proposals in different forms may result in the disqualification of all Proposers knowingly involved.

4.3.8 The State shall reject a proposal if the Cost Proposal was not arrived at independently without collusion, consultation, communication, or agreement as to any matter relating to such prices with any other Proposer. Regardless of the time of detection, the State shall consider any of the foregoing prohibited actions to be grounds for proposal rejection or Contract termination.

4.3.9 The State shall not contract with or consider a proposal from:

4.3.9.1 An individual who is, or within the past six (6) months has been, an employee or official of the State of Tennessee;

4.3.9.2 A company, corporation, or any other contracting entity in which an ownership of two percent (2%) or more is held by an individual who is, or within the past six (6) months has been, an employee or official of the State of Tennessee (this shall not apply either to financial interests that have been placed into a "blind trust" arrangement pursuant to which the employee does not have knowledge of the retention or disposition of such interests or to the ownership of publicly traded stocks or bonds where such ownership constitutes less than two percent (2%) of the total outstanding amount of the stocks or bonds of the issuing entity);

4.3.9.3 A company, corporation, or any other contracting entity which employs an individual who is, or within the past six (6) months has been, an employee or official of the State of Tennessee in a position that would allow the direct or indirect use or disclosure of information, which was obtained through or in connection with his or her employment and not made available to the general public, for the purpose of furthering the private interest or personal profit of any person; or,

4.3.9.4 Any individual, company, or other entity involved in assisting the State in the development, formulation, or drafting of this RFP or its scope of services shall be considered to have been given information that would afford an unfair advantage over other Proposers, and such individual, company, or other entity may not submit a proposal in response to this RFP.

4.3.9.5 For the purposes of applying the requirements of RFP subsection 4.3.9, et. seq., an individual shall be deemed an employee or official of the State of Tennessee until such time as all compensation for salary, termination pay, and annual leave has been paid.

4.3.10 The State reserves the right, at its sole discretion, to waive a proposal's variances from full compliance with this RFP. If the State waives minor variances in a proposal, such waiver shall not modify the RFP requirements or excuse the Proposer from full compliance with such. Notwithstanding any minor variance, the State may hold any Proposer to strict compliance with this RFP.

4.4. INCORRECT PROPOSAL INFORMATION

If the State determines that a Proposer has provided, for consideration in this RFP process or subsequent Contract negotiations, incorrect information that the Proposer knew or should have known was materially incorrect, that proposal shall be determined non-responsive and shall be rejected.

4.5. PROPOSAL OF ADDITIONAL SERVICES

If a proposal offers services in addition to those required by and described in this RFP, the additional services may be added to the Contract before Contract signing at the sole

discretion of the State. Notwithstanding the foregoing, a Proposer shall not propose any additional cost amount(s) or rate(s) for additional services.

NOTICE: The Proposer's Cost Proposal shall record only the proposed cost as required in this RFP and shall not record any other rates, amounts, or information. If a Proposer fails to submit a Cost Proposal as required, the State shall determine the proposal to be non-responsive and shall reject the proposal.

4.6. ASSIGNMENT AND SUBCONTRACTING

4.6.1 The Proposer awarded a Contract pursuant to this RFP may not subcontract, transfer, or assign any portion of the Contract without the State's prior, written approval.

4.6.2 A subcontractor may only be substituted for a proposed subcontractor at the discretion of the State and with the State's prior, written approval.

4.6.3 At its sole discretion, the State reserves the right to refuse approval of any subcontract, transfer, or assignment.

4.6.4 Notwithstanding State approval of each subcontractor, the Proposer, if awarded a Contract pursuant to this RFP, shall be the prime Contractor and shall be responsible for all work performed.

4.7. RIGHT TO REFUSE PERSONNEL

At its sole discretion, the State reserves the right to refuse any personnel, of the prime Contractor or a subcontractor, for use in the performance of a Contract pursuant to this RFP.

4.8. INSURANCE

The State may require the apparent successful Proposer to provide proof of adequate worker's compensation and public liability insurance coverage before entering into a Contract. Additionally, the State may require, at its sole discretion, the apparent successful Proposer to provide proof of adequate professional malpractice liability or other forms of insurance. Failure to provide evidence of such insurance coverage is a material breach and grounds for termination of the Contract negotiations. Any insurance required by the State shall be in form and substance acceptable to the State.

4.9. LICENSURE

Before a Contract pursuant to this RFP is signed, the apparent successful Proposer must hold all necessary, applicable business and professional licenses. The State may require any or all Proposers to submit evidence of proper licensure.

4.10. SERVICE LOCATION AND WORK SPACE

The service pursuant to this RFP is to be performed, completed, managed, and delivered as detailed in the RFP Attachment 6.1, *Pro Forma* Contract. Work space on the State's premises may be available for Contractor use in accordance with the P*ro Forma* Contract or at the State's discretion. Any work performed on the State's premises shall be completed during the State's standard business hours.

4.11. PROPOSAL WITHDRAWAL

A Proposer may withdraw a submitted proposal at any time up to the Proposal Deadline time and date detailed in the RFP Section 2, Schedule of Events. To do so, a Proposer must submit a written request, signed by a Proposer's authorized representative to

withdraw a proposal. After withdrawing a previously submitted proposal, a Proposer may submit another proposal at any time up to the Proposal Deadline.

4.12. PROPOSAL ERRORS AND AMENDMENTS

Each Proposer is liable for all proposal errors or omissions. A Proposer will not be allowed to alter or amend proposal documents after the Proposal Deadline time and date detailed in the RFP Section 2, Schedule of Events, unless such is formally requested, in writing, by the State.

4.13. PROPOSAL PREPARATION COSTS

The State will not pay any costs associated with the preparation, submittal, or presentation of any proposal.

4.14. DISCLOSURE OF PROPOSAL CONTENTS

Each proposal and all materials submitted to the State in response to this RFP shall become the property of the State of Tennessee. Selection or rejection of a proposal does not affect this right. All proposal information, including detailed price and cost information, shall be held in confidence during the evaluation process. Notwithstanding, a list of actual Proposers submitting timely proposals may be available to the public, upon request, directly after Technical Proposals are opened by the State.

Upon the completion of the evaluation of proposals, indicated by public release of an Evaluation Notice, the proposals and associated materials shall be open for review by the public in accordance with *Tennessee Code Annotated*, Section 10-7-504(a)(7). By submitting a proposal, the Proposer acknowledges and accepts that the full proposal contents and associated documents shall become open to public inspection.

4.15. CONTRACTOR REGISTRATION

All service contractors with State of Tennessee contracts must be registered through the Department of Finance and Administration's Service Provider Registry prior to Contract approval. However, registration with the State is not required to make a proposal (any unregistered service provider must simply register as required prior to the final Contract approval). Refer to the following Internet URL for more information about the Service Provider Registry and to register "online."

www.state.tn.us/finance/rds/ocr/sprs.html

4.16. CONTRACT APPROVAL

The RFP and the Contractor selection processes do not obligate the State and do not create rights, interests, or claims of entitlement in either the Proposer with the apparent best-evaluated proposal or any other Proposer. Contract award and State obligations pursuant thereto shall commence only after the Contract is signed by the Contractor and the head of the procuring State agency and after the Contract is approved and signed by all other State officials as required by State laws and regulations.

4.17. CONTRACT PAYMENTS

All Contract payments shall be made in accordance with the Contract's Payment Terms and Conditions provisions (refer to RFP Attachment 6.1, *Pro Forma* Contract, Section C). No payment shall be made until the Contract is approved as required by State laws and regulations. Under no conditions shall the State be liable for payment of any type associated with the Contract or responsible for any work done by the Contractor, even work done in good faith and even if the Contractor is orally directed to proceed with the

delivery of services, if it occurs before Contract approval by State officials as required by applicable statutes and rules of the State of Tennessee or before the Contract start date or after the Contract end date specified by the Contract.

4.18. CONTRACTOR PERFORMANCE

The Contractor shall be responsible for the completion of all work set out in the Contract. All work is subject to inspection, evaluation, and acceptance by the State. The State may employ all reasonable means to ensure that the work is progressing and being performed in compliance with the Contract. At reasonable times, the State may inspect those areas of the Contractor's place of business that are related to the performance of the Contract. If the State requires such an inspection, the Contractor shall provide reasonable access and assistance.

4.19. CONTRACT AMENDMENT

During the course of this Contract, the State may request the Contractor to perform additional work for which the Contractor would be compensated. That work shall be within the general scope of this RFP. In such instances, the State shall provide the Contractor a written description of the additional work, and the Contractor shall submit a time schedule for accomplishing the additional work and a price for the additional work based on the rates included in the Contractor's proposal to this RFP. If the State and the Contractor reach an agreement regarding the work and associated compensation, such agreement shall be effected by means of a Contract amendment. Any such amendment requiring additional work must be mutually agreed upon by the parties and signed by the Contractor and the head of the procuring State agency and must be approved by other State officials as required by State laws and regulations. The Contractor shall not commence additional work until the State has issued a written Contract amendment and secured all required approvals.

4.20. SEVERABILITY

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

5. PROPOSAL EVALUATION AND CONTRACT AWARD

5.1. EVALUATION CATEGORIES AND MAXIMUM POINTS

The State will consider qualifications and experience, technical approach, and cost in the evaluation of proposals. The maximum points that shall be awarded for each of these categories are detailed below.

CATEGORY	MAXIMUM POINTS POSSIBLE
Qualifications and Experience	30
Technical Approach	40
Cost Proposal	30

5.2. EVALUATION PROCESS

The proposal evaluation process is designed to award the Contract not necessarily to the Proposer of least cost, but rather to the Proposer with the best combination of attributes based upon the evaluation criteria.

5.2.1 The RFP Coordinator will use the RFP Attachment 6.3, Technical Proposal and Evaluation Guide, to manage the Technical Proposal Evaluation and maintain evaluation records.

5.2.1.1 The RFP Coordinator will review each Technical Proposal to determine compliance with mandatory requirements (refer to RFP Attachment 6.3, Technical Proposal and Evaluation Guide, Technical Proposal Section A). If the RFP Coordinator determines that a proposal may have failed to meet one (1) or more of the mandatory requirements, the Proposal Evaluation Team will review the proposal and document its determination of whether: (1) the proposal meets requirements for further evaluation; (2) the State will request clarifications or corrections; or, (3) the State will determine the proposal non-responsive to the RFP and reject it.

5.2.1.2 A Proposal Evaluation Team, made up of three (3) or more State employees, will evaluate each Technical Proposal that appears responsive to the RFP.

5.2.1.3 Each Proposal Evaluation Team member will independently evaluate each proposal against the evaluation criteria in this RFP, rather than against other proposals, and will score each in accordance with the RFP Attachment 6.3, Technical Proposal and Evaluation Guide.

5.2.1.4 The State reserves the right, at its sole discretion, to request Proposer clarification of a Technical Proposal or to conduct clarification discussions with any or all Proposers. Any such clarification or discussion shall be limited to specific sections of the proposal identified by the State. The subject Proposer shall put any resulting clarification in writing as may be required by the State.

5.2.2 After Technical Proposal evaluations are completed, the RFP Coordinator will open the Cost Proposals and use the RFP Attachment 6.4, Cost Proposal and Scoring Guide, to calculate and document the Cost Proposal scores.

5.2.3 For each responsive proposal, the RFP Coordinator will add the average Technical Proposal score to the Cost Proposal score (refer to RFP Attachment 6.5, Proposal Score Summary Matrix).

5.3. CONTRACT AWARD PROCESS

5.3.1 The RFP Coordinator will forward the results of the proposal evaluation process to the head of the procuring agency who will consider the proposal evaluation process results and all pertinent information available to make a determination about the Contract award. The State reserves the right to make an award without further discussion of any proposal.

Notwithstanding the foregoing, to effect a Contract award to a Proposer other than the one (1) receiving the highest evaluation score, the head of the procuring agency must provide written justification for such an award and obtain the written approval of the Commissioner of Finance and Administration and the Comptroller of the Treasury.

5.3.2 After the agency head's determination, the State will issue an Evaluation Notice to identify the apparent best-evaluated proposal on the Evaluation Notice date detailed in the RFP Section 2, Schedule of Events.

NOTICE: The Evaluation Notice shall not create rights, interests, or claims of entitlement in either the Proposer with apparent best-evaluated proposal or any other Proposer.

5.3.3 The State will also make the RFP files available for public inspection on the Evaluation Notice date detailed in the RFP Section 2, Schedule of Events.

5.3.4 The Proposer with the apparent best-evaluated proposal must agree to and sign a Contract with the State which shall be substantially the same as the RFP Attachment 6.1, *Pro Forma* Contract.

However, the State reserves the right, at its sole discretion, to add terms and conditions or to revise *Pro Forma* Contract requirements in the State's best interests subsequent to this RFP process. No such terms and conditions or revision of Contract requirements shall materially affect the basis of proposal evaluations or negatively impact the competitive nature of the RFP process.

5.3.5 The Proposer with the apparent best-evaluated proposal must sign and return the Contract drawn by the State pursuant to this RFP no later than the Contract Signature Deadline date detailed in the RFP Section 2, Schedule of Events. If the Proposer fails to provide the signed Contract by the deadline, the State may determine that the Proposer is non-responsive to the terms of this RFP and reject the proposal.

5.3.6 If the State determines that the apparent best-evaluated proposal is non-responsive and rejects the proposal after opening Cost Proposals, the RFP Coordinator will re-calculate scores for each responsive Cost Proposal to determine the new, apparent best-evaluated proposal.

6. RFP ATTACHMENTS

6.1. *PRO FORMA* CONTRACT

The *Pro Forma* Contract detailed in this attachment contains some “blanks” (signified by descriptions in capital letters) that will be completed with appropriate information in the final Contract resulting from this RFP.

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
BUREAU OF TENNCARE
AND
CONTRACTOR NAME

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" and CONTRACTOR LEGAL ENTITY NAME, hereinafter referred to as the "Contractor," is for the provision of the Takeover and Enhancements of the TennCare Management Information System, as further defined in the "SCOPE OF SERVICES."

The Contractor is AN INDIVIDUAL / A FOR-PROFIT CORPORATION / A NONPROFIT CORPORATION / A SPECIAL PURPOSE CORPORATION OR ASSOCIATION / A FRATERNAL OR PATRIOTIC ORGANIZATION / A PARTNERSHIP / A JOINT VENTURE / A LIMITED LIABILITY COMPANY.

Contractor Vendor Identification Number: FEDERAL EMPLOYER ID # OR SOCIAL SECURITY #

Contractor Address: ADDRESS

Contractor Place of Incorporation or Organization: LOCATION

A. SCOPE OF SERVICES AND DELIVERABLES

The Contractor shall provide all service 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 or elsewhere in this Contract.

General Scope of the TCMIS Reprocurement Project:

The Contractor agrees to implement the enhancements, and to perform all Facilities Management services of the TCMIS under the Reprocurement Contract, and any and all amendments thereto, meeting all of the State's requirements in accordance with this Contract, Attachments, and State Request for Proposals Number RFP—318.65-211 incorporated hereto by reference pursuant to Section E.14 of this Contract.

Any reference in this Contract, Contract Attachments, the "RFP", or the "Proposal" shall be construed to reference this Contract, and any reference herein to the "Proposer" shall be construed to reference the Contractor.

A.1 TCMIS Takeover and Enhancements 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 Takeover 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 are managed, produced, and updated by the Contractor. Others are natural work-products arising out of the shared effort of both parties. 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" which 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 life 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; 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 test.

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 Reprocurement 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. Upon receipt of a Notice of Intent to Propose, the State will provide a web-site and password to allow access to and review of the ITM in its entirety. The ITM web-site has embedded "help text" in the ITM documents, and the State has used the word processor's "Hidden Text" feature. Therefore, the Contractor should turn on the Hidden Text feature when viewing ITM documents and templates.

The Project Management Processes category describes the procedures for organizing and controlling the work of the project, which will extend over one (1) or more Product Development Phases. The Product Development Phases describes 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. See Sections A.2.2.1.2 and A.3.20.1.20 for Contractor requirements and deliverables specific to the Bureau's needs.

A.1.2.3.1.1 The following principles have been defined regarding Change Order management:

a) The project scope and any significant changes thereto, particularly those resulting in a Change Order, will be reviewed with and approved by the Project Steering Committee.

b) All project team members shall maintain commitment and adherence to the project scope.

c) All Change Orders will be documented and submitted to the Bureau assigned Project Director, who is responsible for oversight of the Change Order process as outlined in this section.

A.1.2.3.2 Change Order Approach

As with project issues, proposed project Change Orders will be reviewed, prioritized, assigned, and resolved. Change Order resolution differs from issue resolution in that there is an impact on project resources, timeline, and/or budget, with a Change Order that will require approval. Therefore, a justification for the Change Order must 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 will be researched to determine the impact on the project. Frequently, these particular project issues will require a Change Order. For additional details refer to Section A.2.2.1.2.

A.1.2.3.3 Change Order Procedure

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

a) Create & Log Change Order – The process is initiated by an issue being deemed a Change Order. The request will specify the nature of the change and the business justification for the change (the justification may be preliminary – a further evaluation will 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 is assigned an owner by the Project Director (or designee) who will 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 is analyzed to determine its potential impact on the project's budget, resources and schedule within fifteen (15) days of its submission. Costs, benefits, impact on quality, staffing and project risk, and the associated timing of each are evaluated and an analysis is prepared for presentation to the Project Steering Committee.

d) Obtain Approvals – The Cost/Benefit evaluation that is performed during the "Perform Impact Analysis" step in this process is presented to the Project Steering Committee who will approve or reject requested change.

e) Update Project Documentation – If the Change Order request is accepted/approved, project management moves forward with implementing the change. All necessary project documentation is updated accordingly (e.g. project plan, risk assessment).

A.1.2.3.4 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 will be initiated, as a Change Order request will 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 will be used during the Project.

Any issue that comes up during the project that cannot be immediately resolved or requires a decision or action involving those outside the project team will be documented and maintained in the project Issues Log by the Contractor. Anyone on the TCMIS Reprocurement project team may submit a new issue to the Issues Log. An issue can be a decision or question of any size, small or large, which concerns any part of the project. Only the Project Director (or designee) may close an issue, to confirm resolution of the issue before it is no longer tracked.

The Issues Log will allow management to review outstanding questions, decisions and pending actions, and provide guidance on those issues that are of the highest priority. The Issues Log is also 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 Bureau may allow the Contractor to propose a Corrective Action Plan (CAP) to remedy the deficiency or failure. A deficiency or failure occurs when the Contractor fails to correctly meet contractual requirements within the specified time-frames, and includes production issues, testing requirements, performance measures, and enhancement defects. If the Contractor fails to complete the mutually agreed upon CAP, then liquidated damages may be assessed.

A.1.2.4.1 Issue Resolution Procedure

The steps for reporting and resolving a project issue are:

1) Submit Issue - All identified issues will be entered into the Issues Log. An issue may be entered by anyone on the TCMIS Reprocurement project team. The default issue status will be 'Submitted'. Each issue will 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 will be updated as an issue continues to progress through the process.

2) Review and Prioritize Issue - The Project Director (or designee) will review a newly submitted issue and determine whether to accept/assign, reject, or defer the issue. Assigned issues will be prioritized based on the impact the issues have, or will 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 will be immediately escalated to the Project Director (or designee) to be resolved or further escalated, as these will not be resolved at the project team level. Please refer to the Issue Escalation process in paragraph section A.1.2.4.2 Project management will closely monitor the Issues Log as certain unresolved issues could materially impede the progress of the project.

3) Assign Issue to an Owner - The Project Director (or designee) will assign an accepted issue to an owner who will be responsible for driving the issue to resolution.

4) Evaluate Resolution Options - The issue owner will 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 will be responsible for collaborating with others where necessary to evaluate options and reach a resolution.

5) Resolve Issue - The issue owner will work to resolve the issue by the target resolution date. The typical timeframes for resolving an issue are 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 designee) may choose to escalate the issue. The owner of the issue will confer with project

management to determine the appropriate management escalation action to take. See the Issue Escalation Process (Section A.1.2.4.2).

6) Close Issue - Once an issue has been resolved; it will be assigned a 'Closed' status by the Project Director (or designee) in the Issues Log.

If an issue has not been resolved by its assigned target resolution date, then the issue can be automatically escalated. The first level of issue escalation is to the Project Director (or designee). Types of issues that will 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 will 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 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 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 will escalate to the Steering Committee. The issue will be presented to the Steering Committee at its next regular meeting for consideration and resolution.

If the item has not been resolved by the following regular Steering Committee meeting, or if it is an issue that cannot be resolved at the Steering Committee level, then the issue will be escalated to the Executive Sponsors or Commissioner of Finance for final resolution. These executives will consider the issue, and make assignments as needed, to expeditiously resolve the issue.

If the urgency of the issue is such that it cannot wait for resolution until the next regular Steering Committee or Executive Sponsors meeting, the Project Director (or designee) may call a special meeting or arrange a teleconference for consideration of the issue.

A.2 Transition/Implementation of Facility Manager Operations

A.2.1 Transition Methodology

Transition activities will vary depending on whether the incumbent Facilities Manager or a new Proposer wins the Contract. If the incumbent Facilities Manager is awarded the Contract, then activities will include the completion of all TCMIS enhancements and improvements. A new Contractor must provide for receiving and installing a copy of the TCMIS in the Contractor's facility and must demonstrate completeness of the transition, including all TCMIS enhancements and improvements.

As part of the TennCare Management Information System (TCMIS) Takeover, the transition of the Facilities Manager operations will be a critical process to the success of the project. A methodology is a systematic or orderly way of approaching business analysis, information systems and information technology. Analysis of and the potential for re-engineering business processes is an important ingredient in a systems development methodology. As such, there is a need to have methodologies to guide development.

The Contractor shall utilize the State's Information Technology Methodology (ITM) in the development of the transition methodology. The State's ITM is described in section A.1.1. Throughout the project, the Contractor shall produce various Project Management Process and Product Development Phase deliverables. The minimum set of deliverables and responsibilities for the transition are defined in Section A.2 of the Contract.

Since the State's ITM is defined at a high-level for use on all types and sizes of IT projects, the Contractor shall develop and utilize a detailed transition methodology within the guidelines of the State's ITM and development standards for use in the transition of the Facilities Manager functions to promote consistency and continued flexibility in the TCMIS.

A.2.1.1 Transition Methodology Deliverables

The following deliverables are required as part of the transition methodology:

A.2.1.1.1 Contractor Comprehension of Project

A description of the methods by which the Contractor plans to accomplish all of the work beginning with an overall plan that demonstrates an understanding of the nature and desired results of the project.

A.2.1.1.2 Methodology

A detailed description of the basic concept and proposed methodology for accomplishing the necessary tasks outlined in the Transition and Implementation Activities, Assessments and Deliverables Section, A.2.2, and Operational Readiness Section, A.2.3, of this Contract.

A.2.1.1.3 Strategy

The overall transition process strategy, demonstrating the manner in which all work elements will be combined into the production of the desired results.

A.2.2 Transition and Implementation Activities, Assessments and Deliverables

As part of the TennCare Management Information System (TCMIS) Reprocurement Contract, certain deliverables will be required as part of the transition and implementation by the Facilities Manager Contractor. For each transition task deliverable, the Contractor must prepare a cost benefit analysis including a cost estimate for the implementation of the recommendation or recommendations.

The following transition deliverables have been identified and loosely grouped into five (5) areas:

- TCMIS Assessment
- Planning
- System Testing/Verification/Validation
- Transition and Implementation Completeness
- Assumption of TCMIS Functions

A.2.2.1 TCMIS Assessment

A.2.2.1.1 Web

The Contractor must review and assess the current business application that could be replaced or improved upon using Web technology to facilitate various interface processes.

TennCare currently utilizes the Web to support various communications with the public, enrollees, and providers. Within the Provider enrollment function, the WEB is currently used to assist providers in obtaining the necessary forms needed for enrollment in the TennCare program, (for both TennCare and Medicare/ Medicaid cross-over claims). However, it offers downloadable forms for the Provider to submit information to the TennCare Bureau, and is not real-time. The Bureau wants the Contractor to assess this process to allow providers to enter the enrollment information online and immediately obtain a provider number and create a web portal account for new providers. Also, for providers who do not wish to enroll via the web, the option to download an enrollment form from a link should still be offered.

The Web interface is also needed to facilitate the Preadmission Evaluation (PAE) process to support Medicaid reimbursements to nursing homes or waiver programs for the elderly or disabled.

The Contractor must provide the following Web Deliverables:

A.2.2.1.1.1 Cost/benefit analysis that includes the cost estimate for implementation of recommendations.

A.2.2.1.1.2 Assessment/recommendation paper on Web processes, which is due no later than March 31, 2008. Recommendations must be based on best interests of the State, with the goal of attaining operational efficiencies while maintaining necessary process control of key business information.

A.2.2.1.1.3 Informal presentation to Bureau staff, which should describe the Contractor's recommendation, the procedures used by the Contractor to gather the information needed to make the recommendation and a cost/benefit analysis.

A.2.2.1.2 Change Management

Changes in the TCMIS are done through either maintenance or fixes, currently referred to as a Work Request, or modifications/enhancements/changes, currently referred to as a System Change Request. The Contractor will be responsible for the open requests at time of takeover and all new requests. During the transition, the Contractor must monitor and participate in the change management activities to ensure procedures and processes are appropriately followed when a change is implemented. The Contractor will need to coordinate all change requests with the prior Facilities Manager, participate in Change Control Board meetings, utilize Serena® TeamTrack® software to monitor the change requests, track status and progress of change orders and prepare reports on open/closed requests and prioritized items.

The Contractor must provide the following Change Management Deliverable:

A.2.2.1.2.1 Change request reports, including status and priority, which are due weekly during the transition.

A.2.2.1.2.2 Conduct a review of change management and tracking procedures and provide an assessment and recommendations for processes and tools pertaining to change management and IT governance.

A.2.2.1.3 Version Control / Source Code Control

The Contractor must review, assess, and recommend improvements and enhancements to the Bureau of TennCare's version and source code control software and processes. Version Control and Source Code Control is the management of multiple revisions of the same unit of information. Revision control addresses issues such as team coordination - to ensure that only one (1) person at a time is modifying a file, which prevents files from accidentally being replaced by another user's changes - and version tracking - archiving and tracking of old versions of source code and other files. Version Control/Source Code Control, which manages the multiple versions of modules as they progress through the software development or maintenance processes, is critical to the success of the TCMIS transition to validate the correct software is being run when the takeover is complete.

The Contractor must provide the following Version Control/Source Control Deliverables:

A.2.2.1.3.1 Cost/benefit analysis that includes the cost estimate for implementation of recommendations.

A.2.2.1.3.2 Recommendation paper on version and source code control software and processes, which is due no later than May 1, 2008. Recommendations must 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.2.2.1.3.3 Informal presentation to Bureau staff, which should 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.2.2.1.4 Medicaid Information Technology Architecture (MITA)

The Contractor must conduct a MITA State self-assessment of the Bureau's 'as is' and 'to be' concept of operations. The Medicaid Information Technology Architecture (MITA) initiative is a structured effort to provide a national Architecture framework in which Medicaid business areas drive technology. MITA is a business driven methodology. MITA can improve Medicaid program administration by aligning business processes and supporting technology with national guidelines. The MITA initiative includes the framework, processes, and planning guidelines that allow states to meet their objectives within the MITA Framework 2.0 while continuing to support the unique State needs.

The MITA Framework 2.0 is a consolidation of principles, business and technical models, and guidelines that creates a template for States to use to develop their individual enterprise architectures. In the future, MITA guidelines will support States' requests for appropriate Federal Financial Participation (FFP) for their Medicaid Management Information Systems (MMISs). Advance Planning Documents (APDs) and RFPs will show the results of the self-assessment and the targets for improvement that a new MMIS or business process upgrades are meant to achieve.

The Centers for Medicare and Medicaid (CMS) expects the Bureau of TennCare to take steps to migrate toward the new MITA framework. The Bureau is committed to the guidelines and objectives for MITA and is preparing for future enhancements to meet those objectives, including, but not limited to, having a State self-assessment done.

The Contractor must provide the following MITA Deliverables:

A.2.2.1.4.1 Cost/benefit analysis that includes the cost estimate for implementation of recommendations.

A.2.2.1.4.2 State Self-Assessment of 'as is' and 'to be' concept of operations, which is due no later than June 30, 2008. Recommendations must 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.2.2.1.4.3 Informal presentation to Bureau staff, which should 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.2.2.1.5 Recipient and Provider Linking

The Contractor must review, assess and propose recommendations for improvement to the recipient and provider linking processes. The current TCMIS has coding that was defined by Bureau of TennCare business users to link members (recipients). A recipient linking process runs daily and monthly for recipients who have a former ID that is now linked to a new ID. However, the current recipient linking process is unable to link numerous recipients. Additionally, the current TCMIS does not have a methodology for systematically linking providers. Any recommendations will need to be integrated with the current interChange system. Additionally, the Contractor must ensure the continuity of the recipient linking/unlinking based on the new DHS eligibility interface project, (Vision Integration Platform (VIP). (See Section 6.10, paragraph 6.10.1.1.2).

The Contractor must provide the following Recipient and Provider Linking Deliverables:

A.2.2.1.5.1 Cost/benefit analysis that includes the cost estimate for implementation of recommendations.

A.2.2.1.5.2 Recommendation paper on recipient and provider linking processes, which is due no later than July 31, 2008. Recommendations must 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.2.2.1.5.3 Informal presentation to Bureau staff, which should 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.2.2.1.6 MAR Review

The Contractor must review and assess the current Management and Administrative Reporting (MAR) processes and provide recommendations for improving those

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 will be retrieved from various TCMIS files/database tables for analysis and summarization. The Contractor must validate all needed MAR activities are being done and are done correctly.

The Contractor must provide the following MAR Deliverables:

A.2.2.1.6.1 Cost/benefit analysis that includes the cost estimate for implementation of recommendations.

A.2.2.1.6.2 Recommendation paper on MAR processes, which is due no later than July 31, 2008. Recommendations must 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.2.2.1.6.3 Informal presentation to Bureau staff, which should 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.2.2.1.7 SUR Review

The Contractor must review and assess the Surveillance and Utilization Review (SUR) Subsystem processes and provide recommendations for improving those processes. The SUR function identifies, reports on and supports the investigation of potential misuse of the medical assistance programs by providers and enrollees. The SUR process creates 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 analyzes historical data, develops profiles of health care delivery, and reports 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 provides 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 will be performed for the fee-for-service and the managed care programs. The Contractor will be responsible for the operation and maintenance of the SUR component of the TCMIS. The SUR functional area of the current TCMIS is used to monitor both fee-for-service and encounter claims processed by the Bureau of TennCare for fraud and abuse by providers and recipients. All requirements of a SUR subsystem must 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 four (4) components: Targeted Queries, DSSProfiler, WebStation and the Ad Hoc solution. The Contractor must validate all needed SUR activities and processes are being done and are done correctly.

The Contractor must provide the following SUR Deliverables:

A.2.2.1.7.1 Cost/benefit analysis that includes the cost estimate for implementation of recommendations.

A.2.2.1.7.2 Recommendation paper on SUR processes, which is due no later than July 31, 2008. Recommendations must 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.2.2.1.7.3 Informal presentation to Bureau staff, which should 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.2.2.1.8 Mailroom

The Contractor must review the Mail Room efficiency and cost effectiveness. The Contractor shall recommend a process to obtain the most current mailing address to decrease the volume of undeliverable mail. As part of the recommendation, the Contractor will need to establish the undeliverable mail rate and develop a plan to drop the rate by fifty percent (50%) within two (2) years of Contract start date. The Contractor could possibly develop a mechanism to hold notices that have been marked as undeliverable until an accurate address can be identified.

The Contractor must provide the following Mailroom Deliverables:

A.2.2.1.8.1 Cost/benefit analysis that includes the cost estimate for implementation of recommendations.

A.2.2.1.8.2 Recommendation paper on Mailroom efficiency, which is due no later than March 31, 2008. Recommendations must 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.2.2.1.8.3 Informal presentation to Bureau staff, which should 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.2.2.1.9 TCMIS Performance

The Contractor Database Administrators (DBAs), in coordination with OIR and the Bureau, must evaluate and recommend performance tuning enhancements for the TCMIS. The assessment should include a review of the system performance, application performance and SQL performance. Additionally, the assessment should include a model whereby database and application performance is addressed in the system design and development process. This model should include at a minimum the involvement of the DBAs in the review and approval of database changes during design and development processes. The Contractor must utilize a performance tool, which will increase productivity and quality of work when determining application and system problems. The performance tool should have an alert capability, which will take the Bureau from reactive mode to proactive mode, resulting in problem resolution before major problems occur. The Contractor must review the database system settings and parameters, applying industry standards and rules of thumb to the evaluation process,

yet realizing that every system is different and thus taking into consideration the characteristics of the TCMIS. Past incident and problem situations should be reviewed to determine patterns of inefficiency and a 'lessons learned' repository should be developed for coding practices, database design, and others as identified. For example, pull out the top ten (10) poor performing SQL and applications to review.

The Contractor should provide metrics, execution and/or other status for a performance test effort. Contractor staff should have knowledge of Oracle databases, along with skills in data manipulation mechanisms, such as SQL, stored Procedures and triggers. Recommendations should include changes and/or upgrades that improve performance by a statistically significant amount in areas including, but not limited to:

1. Improve response time

2. Identify poor performing SQL

3. Increase throughput

4. Reduce overall CPU usage

5. Improve I/O performance

Achieving performance goals can result in:

1. A reduction in hardware costs

2. Greater database productivity

3. Higher quality overall performance to better serve the needs of the Bureau and the enrollees

The Contractor shall replace or revise system functionality or processes whereby the performance is not acceptable to the Bureau.

The Contractor must provide the following TCMIS Performance Deliverables:

A.2.2.1.9.1 Cost/benefit analysis that includes the cost estimate for implementation of recommendations.

A.2.2.1.9.2 Recommendation paper on performance tuning enhancements, which is due no later than August 29, 2008. Recommendations must 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.2.2.1.9.3 Informal presentation to Bureau staff, which should 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.2.2.1.10 State Software Licenses

The Contractor must evaluate the software licenses that are owned by the State and recommend changes that could produce savings for the State. Specifically, the Contractor should review the licenses and maintenance agreements that the State owns against the licenses and maintenance agreements the Contractor could get for the same software. The current list of software owned by the State that would need to be evaluated includes, but is not limited to, Oracle database, Oracle financials, Sybase translator, Seibel and FileNet, Citrix, RRI, AVRS, NICE, and AVAYA CTS.

The Contractor must provide the following Software Licenses Deliverables:

A.2.2.1.10.1 Cost/benefit analysis that includes the cost estimate for implementation of recommendations.

A.2.2.1.10.2 Recommendation paper on software licenses, which is due no later than June 30, 2008. Recommendations must 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.2.2.1.10.3 Informal presentation to Bureau staff, which should 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.2.2.1.11 Workflow Management

The Contractor must review, assess, and recommend improvements and enhancements to the Bureau of TennCare's use of its Work Flow Management software. The Bureau of TennCare needs its workflow management solution(s) to efficiently manage the deadline sensitive workflows both within the Bureau of TennCare environment and with Bureau of TennCare business partners. Currently, the AVAYA Enterprise Workflow Manager (AEM) automates processes that used to be done manually. Several technical applications have been integrated to efficiently manage the work processes that comprise the TCMIS. These applications work together to provide assistance in the management of deadline sensitive processes. The assembled workflow management solution currently includes the interChange TCMIS, Computerized Telephony System, and the document imaging solution. Recommendations must support workflow routing and critical object management among TCMIS end-users and business partners (e.g. managed care contractors, State agencies and other approved entities) and be integrated with the TCMIS and integrated components.

The Contractor must provide the following Workflow Management Deliverables:

A.2.2.1.11.1 Cost/benefit analysis that includes the cost estimate for implementation of recommendations.

A.2.2.1.11.2 Recommendation paper on Workflow Management software use, which is due no later than May 30, 2008. Recommendations must 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.2.2.1.11.3 Informal presentation to Bureau staff, which should 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.2.2.1.12 Operations Functionality

The Contractor must review the work of the current Facilities Manager operations for verification that all activities are functioning properly in preparation for a smooth transition and make recommendations for improved operating procedures.

Within Operations preparation, the Contractor must conduct staff training on manual and automated functions to ensure that they have a complete understanding of each function of the TCMIS. Operating procedures shall be updated as needed.

The Contractor must provide the following Operations Functionality Deliverables:

A.2.2.1.12.1 Cost/benefit analysis that includes the cost estimate for implementation of recommendations.

A.2.2.1.12.2 Recommendation paper on operating procedures, which is due no later than August 29, 2008. Recommendations must 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.2.2.1.12.3 Staff training and updating of operating procedures, which is due no later than October 31, 2008.

A.2.2.1.12.4 Informal presentation to Bureau staff, which should 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.2.2.1.13 Oracle Financials

The Contractor must review the Bureau of TennCare's use of Oracle Financials and make recommendations for the optimal use of Oracle Financials by the Bureau, especially in regards to premium billing and federal reporting, including, but not limited to, the CMS-64 report.

The current TCMIS uses Oracle Financials to process enrollee premiums and it is used as an accounting package for the Bureau of TennCare. There have been numerous problems with the use of Oracle Financials for processing premiums. Additionally, the finance staff at the Bureau is essentially maintaining two (2) accounting systems because they are required to use Statewide Accounting and Reporting System (STARS) as the accounting system of record (process will be changed to utilize the new ERP system (Edison) when implemented). At the time Oracle Financials was implemented by the Bureau, the Bureau was unable to get good information from STARS. However, STARS now has a Financial Data Access System (FDAS) reporting tool that has increased the Bureau's finance department's access to STARS financial data. The Oracle Financials tools in the Accounting subsystem are used for most of the financial balancing and reporting requirements for management of Managed Care Contractors.

The 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 Premium Management function facilitates the 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), The Department of Human Services (DHS) calculates the premium amount that the enrollee will be required to pay, and forwards this information to the TCMIS. The Premium billing process is currently done within the Oracle Financials function. Letters advising new enrollees of premium amounts and payment schedules are sent from the 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.

The Contractor must provide the following Oracle Financials Deliverables:

A.2.2.1.13.1 Cost/benefit analysis that includes the cost estimate for implementation of recommendations.

A.2.2.1.13.2 Recommendation paper on Oracle Financials use, which is due no later than June 30, 2008. Recommendations must 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.2.2.1.13.3 Informal presentation to Bureau staff, which should 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.2.2.2 Planning

A.2.2.2.1 Risk Management

The Contractor must conduct risk management activities associated with Facilities Manager operations and present a Risk Management/Mitigation Plan, including a strategy for identifying, assessing and mitigating risk. The Plan should address the structure for reporting risks, who is involved in planning risk mitigation strategies, and when the risk strategy will be implemented.

The Contractor must provide the following Risk Management Deliverables:

A.2.2.2.1.1 Risk Management/Mitigation Plan, which is due no later than April 30, 2008.

A.2.2.2.1.2 Informal presentation to Bureau staff, which should describe the Contractor's Plan, the procedures used by the Contractor to gather the information needed to prepare the Plan and a cost/benefit discussion.

A.2.2.2.2 Transition and Implementation Plan

The Contractor must include a proposed Implementation Plan that must address the Bureau's desire to reduce risk during transition and implementation of the systems. Upon completion of Pre-Implementation activities, the Bureau will authorize final dates for the implementation of the TCMIS, based on dates in the approved implementation schedule. The Contractor must implement the TCMIS without interruption in beneficiary eligibility verification, provider enrollment, or claims payment. Implementation of the Facilities Manager operations must ensure there is no disruption to State and federal reporting activities.

The Contractor must successfully plan for and perform the TCMIS transition and implementation (this step is likely to be minimized if the current Contractor is the successful bidder). The Contractor will transition the current TCMIS to its own hardware, installing all software and the telecommunications networks required to operate the system according to the specifications outlined in the current system documentation and the Contract. The Contractor will also transfer or develop any software necessary to perform its operational responsibilities (e.g. data entry, claims control, electronic claims submission software). For the purpose of the transfer and installation task, the TCMIS shall be defined as components and includes licensed software and systems. The Contractor will be required to parallel the system on their hardware. However, the system will need to be transferred to State hardware for operations.

The Bureau must approve the content and format of all deliverables at the outset of the Implementation Phase. The Bureau must approve each and every Implementation Phase activity before it occurs. 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 must provide the following Transition and Implementation Plan Deliverables:

A.2.2.2.2.1 Transition and Implementation Plan, which is due no later than February 1, 2008.

A.2.2.2.2.2 Informal presentation to Bureau staff, which should describe the Contractor's Plan, the procedures used by the Contractor to gather the information needed to prepare the Plan and a cost/benefit discussion.

A.2.2.2.3 Contingency Plan

The Contractor must prepare a Contingency Plan for all business process functions and systems operations functions of the Facilities Manager operations. If any part of the TCMIS or other Facilities Manager operations does not perform according to specifications, the Contractor must execute the appropriate section of its Contingency Plan.

The Contractor must provide the following Contingency Plan Deliverables:

A.2.2.2.3.1 Contingency Plan, which is due no later than February 1, 2008.

A.2.2.2.3.2 Informal presentation to Bureau staff, which should describe the Contractor's Plan, the procedures used by the Contractor to gather the information needed to prepare the Plan and a cost/benefit discussion.

A.2.2.2.4 Requirements Analysis/System Design Plan

The Contractor must conduct a thorough Requirements Analysis to prepare the Transition and Implementation to address all systems and must not be limited to just the core TCMIS subsystems. This analysis must include an in depth assessment and thorough understanding of the TCMIS applications and operational environment of the existing systems. This assessment must fully address the 'as is' state of the TCMIS systems. Additionally, the Contractor must address all requirements statements contained in the Systems Requirements sections in Sections A.2.4 through A.2.5 of this Contract. The Contractor must also produce Requirements Analysis documentation, in formats approved by the Bureau. After the Requirements Analysis is complete, the Contractor must establish and maintain the system design/enhancement activity using an Information Systems Development Methodology (ISDM).

The Contractor must provide the following Requirements Analysis/System Design Plan Deliverables:

A.2.2.2.4.1 Requirements Analysis including analysis of current TCMIS operations, which is due no later than May 30, 2008.

A.2.2.2.4.2 Conduct Joint Application design (JAD) sessions to ensure the requirements definition and analysis supports the Bureau's business processes.

A.2.2.2.4.3 System Design Plan utilizing an ISDM for all TCMIS systems.

A.2.2.2.4.4 System Design Plan utilizing an ISDM for Enhancement functionality incorporated into the TCMIS.

A.2.2.2.4.5 Presentation of Requirements Analysis to Bureau staff.

A.2.2.2.4.6 Presentation of System Design Plan to Bureau staff.

A.2.2.2.5 Transition Staffing Plan

The Contractor must prepare the Transition and Implementation Plan to include a Transition Staffing Plan, which must 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 the Contract.

The Contractor shall provide key personnel, who have previous experience of providing quality work on projects of similar scope and size, to ensure a successful transition and implementation 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 must procure a building site within ten (10) miles of the TennCare building and prepare adequate space to accommodate the new Contractor's staff. This shall include office space to accommodate Bureau and Independent Verification and Validation (IV&V) vendor staff, if required, and sufficient free parking. This may be a phased process to accommodate a build-up in accordance with the takeover plan of action, if appropriate. The Contractor must provide sufficient staff, both on-site and elsewhere, to accomplish all tasks identified in the Transition and Implementation Plan. The Contractor shall provide experienced, qualified professionals to ensure the success of this project. The State has prior approval of key personnel, including anyone who reports to the Transition Project Manager position, which is described in further detail in the Staffing Section A.6. Where appropriate, the same person may be able to fill a position in different Contract phases. For example, the State expects many of the Transition Phase personnel to move into the Operations Phase.

The Contractor must provide the following Transition Staffing Plan Deliverables:

A.2.2.2.5.1 Transition Staffing Plan, which is due no later than February 1, 2008.

A.2.2.2.5.2 Informal presentation to Bureau staff, which should describe the Contractor's Plan, the procedures used by the Contractor to gather the information needed to prepare the Plan and a cost/benefit discussion.

A.2.2.2.6 Communication Plan

The Contractor must create a Communication Plan during the Transition Phase that ensures timely and appropriate generation, collection, and dissemination of the Transition information. The Communication Plan shall be updated throughout the transition to reflect current information. The Bureau realizes the critical nature of effective project communication to provide the links for people (project staff, sponsors, and internal and external stakeholders), information, and ideas that are essential for project success. The Communication Plan ensures that the correct individuals receive required information in a timely manner. In order to ensure that everyone is prepared to send and receive communication in the most effective manner, a plan for managing project communication is required. The Communication Plan shall define the information and communication needs of the stakeholders, including who needs access to project information, what information is needed, when it will be needed, and how the information will be provided to them. This includes the communication protocols and procedures for reporting on Transition issues, work activities, tasks, and deliverables.

The Contractor shall utilize the following information for communication planning: project organization; project stakeholder responsibilities and relationships; familiarity with the TennCare programs and policies; identification of individuals that will be involved in the communication process and their locations; external information needs, including the media, governmental agencies, and other interested parties; availability of communication technology; and constraints and assumptions, relating to communication methods or media. The Plan must include an online repository of all communication materials, and presentations; and ensure that version control, indexing, and storage/retrieval of all communication is securely controlled.

The Contractor must update the Communication Plan throughout the Transition and Implementation activities, and continue updating until a possible new Facilities Manager has completed takeover of TCMIS operations. The Communication Plan shall include the following:

1. Collection structure

2. Distribution structure, for authorized users

3. Description of information to be disseminated

4. Templates to be utilized

5. A method for updating the Communication Plan

6. Schedules listing when information will be produced

The Contractor must provide the following Communication Plan Deliverables:

A.2.2.2.6.1 Communication Plan, which is due no later than February 1, 2008.

A.2.2.2.6.2 Informal presentation to Bureau staff, which should describe the Contractor's Plan, the procedures used by the Contractor to gather the information needed to prepare the Plan and a cost/benefit discussion.

A.2.2.2.7 Transition and Implementation Schedule

The Contractor must prepare, in conjunction with the prior Facilities Manager Contractor, the Project Director and the appropriate staff within the Bureau, a detailed Transition and Implementation Project Schedule depicting all specific tasks to be completed, with deadlines, for the Transition and Implementation. Upon receipt of the Authorization to Begin Work, the Contractor will begin formal Transition and Implementation Planning. During this period, the Contractor will plan and prepare to assume all responsibilities of the TCMIS Facilities Manager. If necessary, the Contractor shall plan to phase in operations on a schedule that will minimize risk. Transition and Implementation activities will end when the new Contractor successfully assumes all Facilities Manager responsibilities and takes over complete operation of the TCMIS.

The Contractor must plan and schedule all Transition and Implementation endeavors utilizing the methodologies, and following the specifications for activities, tasks, requirements and deliverables that are outlined in Section A.2. The Contractor must create, and submit for Bureau approval, a schedule for all transition activities and assumption of all Facilities Manager processes.

The Bureau and the Contractor will work together during initial Contract startup to establish a schedule for installing the TCMIS in the Contractor's facility, if the Contractor is not the incumbent. This schedule will be used by the Contractor in developing the detailed project Work Plan for the Transition and Implementation. During the start of this task, the Contractor will work with the Bureau to define project management and reporting standards, establish communication protocols, and provide orientation on the Contractor's approach to the transition. The Contractor will also define hardware and software requirements that must be installed for a successful transfer, including, but not limited to, networking infrastructure, PC's, Servers, operating systems, PC software, and other applications.

Transition and Implementation Schedule Deliverables

A.2.2.2.7.1 Draft Transition and Implementation Project Schedule, included with proposal response to this Contract

A.2.2.2.7.2 Completed Transition and Implementation Project Schedule, which is due no later than February 1, 2008

A.2.2.2.7.3 Informal presentation to the Bureau

A.2.2.2.8 Transition and Implementation Work Plan

In this transition planning task, the Contractor will submit a formal Transition and Implementation Work Plan that must adhere to required and standard Work Breakdown Structure (WBS).The project Work Plan will be used by the Bureau as a tool to monitor the progress of all tasks. The Contractor must clearly define each task and subtasks and specify a completion task for each activity. Any changes from current operating procedures must be clearly identified and reflected in other sections of the document.

The Contractor must also clearly describe the hardware and software configurations and telecommunications network required for the appropriate sections of the project Work Plan.

Transition and Implementation Work Plan Deliverables

A.2.2.2.8.1 Transition and Implementation Work Plan, which is due no later than February 1, 2008.

A.2.2.2.8.2 Informal presentation to the Bureau.

A.2.2.2.8.3 Configuration Management Plan, which is due no later than March 31, 2008.

A.2.2.2.8.4 The Configuration Management Plan must include the Contractor's version management strategy.

A.2.2.2.8.5 The Configuration Management Plan must include the Contractor's build management strategy.

A.2.2.2.8.6 The Configuration Management Plan must include the Contractor's release management strategy.

A.2.2.2.8.7 The Configuration Management Plan must include the Contractor's change management strategy.

A.2.2.3 System Testing/Verification/Validation

A.2.2.3.1 System Testing

The Contractor must create, and deliver to the Bureau of TennCare, comprehensive and thorough Transition and Implementation Testing Plans before technical design of enhancements is complete. The system testing plans must incorporate Unit, Structured, initial User Acceptance Testing (UAT) and plans for operational readiness testing which occur prior to the Operations Readiness Testing Period, final User Acceptance Testing, Parallel Testing and volume or load testing. The Bureau will review all test results, with a special focus on structured data tests, user acceptance tests, parallel tests, and retests of failed items. The Bureau will not approve the TCMIS for implementation until all tests pass to the satisfaction of the Bureau. The Contractor must revise and retest as often as necessary to meet Bureau requirements.

The Contractor must provide all documentation for the software being tested before acceptance testing will begin. The Bureau will have five (5) working days to review each deliverable outlined within the Transition and Implementation Schedule and to either notify the Contractor of acceptance or to provide the Contractor a detailed list of deficiencies that must be remedied. In the event that the Bureau notifies the Contractor of deficiencies, the Contractor must correct the deficiencies within five (5) working days, unless the Bureau consents in writing to a different timetable.

Upon notification by the Contractor that the TCMIS has been fully implemented and is ready for final system acceptance testing, the Bureau will have thirty (30) days to evaluate and test the systems to confirm that they perform without any defects and perform pursuant to the specifications set forth in this Contract. The Contractor must participate in the acceptance testing of the system by providing technical staff at the Bureau of TennCare location to provide assistance in demonstrating all functions of the system. The Bureau must signoff on each application to ensure that the use meets the functional and technical requirements. In the event that one (1) or more applications supplied by the Contractor are not accepted, the Contractor must correct the deficiencies or provide, at its own expense, software that may be required to meet the acceptance criteria within ten (10) calendar days or a mutually agreed upon period.

The Contractor will be required to demonstrate completeness of the baseline system Transition and Implementation during the Parallel Testing task. Completeness will be measured by the completion and submission of Transition and Implementation Activities, Assessments and Deliverables that are listed in Section A.2.2 and A.2.3. The outputs produced by the Contractor with the TCMIS should be the same as the outputs produced by the current TCMIS for the same inputs. Additional outputs may also be required when enhancements are implemented.

Contractor System Testing Deliverables

A.2.2.3.1.1 Unit Testing Plans and schedule for Transition and Implementation Testing

A.2.2.3.1.2 Structured Testing Plans and schedule for Transition and Implementation Testing

A.2.2.3.1.3 User Acceptance Testing Plans and schedule for Transition and Implementation Testing

A.2.2.3.1.4 Present Unit Test results to Bureau

A.2.2.3.1.5 Present Structured Test results to Bureau

A.2.2.3.1.6 Present User Acceptance Test results to Bureau

A.2.2.3.2 System Verification and Validation

Independent Verification and Validation (IV&V) is a set of Verification and Validation activities performed to analyze system test results by an entity that is not under the control of the Contractor. The Bureau will select an IV&V Services Vendor that is technically, managerially and financially independent of the Contractor who will 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 will be acting with the full authority of the Bureau in performing its evaluation activities.

The selected IV&V Vendor will be required to perform the following series of Verification and Validation tasks. The Contractor will be required to provide access to systems, data, personnel, and documentation as appropriate to support these activities.

1) Project Management

The IV&V Vendor will evaluate project progress, resources, budget, schedules, work flow, and reporting. The IV&V vendor will 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 will evaluate project progress, resources, budget, schedules, work flow, and reporting. The vendor will 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 will evaluate and make recommendations on the project's process and procedures for managing requirements.

4) Operating Environment

The IV&V Vendor will 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 will 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 will review training and make recommendations on the training provided to system users. This will include verifying sufficient knowledge transfer for maintenance and operation of the system.

7) System and Acceptance Testing

The IV&V Vendor will 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 will 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 will 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.2.2.3.2.1 Contractor Responsibilities for IV&V

The Contractor responsibilities listed below are the minimum required under this Contract. The Bureau and the Contractor may agree to assign additional responsibilities which may be incorporated into this Contract through an Amendment.

A.2.2.3.2.1.1. 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.2.2.3.2.1.2. Provide the IV&V Vendor access to project software development documents;

A.2.2.3.2.1.3. Facilitate IV&V Vendor review and monitoring of development processes to ensure they are being documented, carried out, and analyzed for improvement;

A.2.2.3.2.1.4. Facilitate IV&V Vendor review of project deliverables for accuracy, completeness, and adherence to contractual and functional requirements;

A.2.2.3.2.1.5. Facilitate IV&V Vendor review of the system documentation (e.g. Requirements, Training, Test Plans) for accuracy and completeness;

A.2.2.3.2.1.6. 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.2.2.3.2.1.7. Facilitate IV&V Vendor assessment of software testing;

A.2.2.3.2.1.8. Facilitate IV&V Vendor assessment of user and system training;

A.2.2.3.2.1.9. Facilitate IV&V Vendor review of system hardware and software configuration; and

A.2.2.3.2.1.10. 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.2.2.3.2.2 Contractor Deliverables for IV&V

A.2.2.3.2.2.1. Provide IV&V Vendor Project Work Plans

A.2.2.3.2.2.2. Provide IV&V Vendor Unit Test Plans and schedule

A.2.2.3.2.2.3. Provide IV&V Vendor Structured Test Plans and schedule

A.2.2.3.2.2.4. Provide IV&V Vendor User Acceptance Test Plans and schedule

A.2.2.3.2.2.5. Give IV&V Vendor test results daily, as tests are performed.

A.2.2.4 Transition and Implementation Completeness

Transition and Implementation will be considered complete when the Contractor has fulfilled the requirement to successfully run all systems and components of the TCMIS on its own hardware and software, and successfully run parallel testing on the State's hardware that will be used for ongoing operations. The Contractor must have installed the most recent versions of the TCMIS, including, but not limited to, all subsystem programs, online programs, telecommunications, data entry software, and test files and replacements for licensed software and systems as described throughout this Contract. If any issues develop, the Contractor must coordinate with the Bureau to resolve problems encountered during the installation of the TCMIS onto the State's hardware.

The Contractor must provide the following Transition and Implementation Completeness Deliverables:

A.2.2.4.1 Operational Readiness Work Plan

A.2.2.4.2 Weekly reports, or as required by the Bureau, as to the progress of tasks within the Operational Readiness Work Plan, and have this information available online in the documentation repository.

A.2.2.4.3 Completed Transition and Implementation, which is due no later than January 1, 2009.

A.2.2.4.4 Complete TCMIS Infrastructure Documentation, as detailed in Sections A.5.8 and A.5.9.

A.2.2.4.5 Formal presentation to Bureau staff outlining the completed Transition and Implementation Schedule and Work Plan.

A.2.2.5 Assumption of TCMIS Functions

The Contractor shall perform specific implementation functions during the Transition and Implementation, as listed below. The Contractor must implement a fully operational TCMIS on January 1, 2009, or a date to be approved by the Bureau. The Contractor will receive, and be responsible for processing, claims received after January 1, 2009, or a date to be approved by the Bureau. The Contractor will also be responsible for all enrollment and eligibility functions starting on that same date. The eligibility function

accepts and maintains accurate, current and historical information on individuals who have applied for TennCare. The enrollment function determines Managed Care Contractor (MCC) assignments and generates enrollment rosters. The enrollment data is also used for capitation processing and adjustments. The TCMIS functions also include, but are not limited to, managed care, drug rebate, financial operations, quality assurance, fraud and abuse oversight, generating notices and processing for grievances and appeals.

Fully operational is defined as processing correctly all claim types, including encounters, all claims adjustments and mass adjustments, and other financial transactions; maintaining all system files; providing access to all supporting components, including, but not limited to, eligibility, enrollment, TPL, and drug rebate; producing all required reports; meeting all system requirements; and performing all other Contractor responsibilities specified in this Contract. If the Bureau determines the system will not be operational on January 1, 2009, then implementation readiness assessments will be made until such time as the Bureau determines that either a) the system is fully operational or b) that the Contractor shall be deemed in default.

A.2.2.5.1 Contractor Responsibilities

A.2.2.5.1.1 Conduct orientation and training for Bureau personnel on Contractor organization, functional responsibilities, and operational procedures.

A.2.2.5.1.2 Implement operational plan.

A.2.2.5.1.3 Allow for the complete resolution of all outstanding issues, (e.g. edits and adjudication of claims) by the prior Facilities Manager to be transferred.

A.2.2.5.1.4 Conduct weekly status meetings with the TCMIS Project Manager and other Bureau staff and post meeting notes online in the documentation repository, if appropriate.

A.2.2.5.1.5 Determine status of TCMIS according to Transition and Implementation Plan, and identify and report to the Bureau any implementation features that are behind schedule according to the Transition and Implementation Plan.

A.2.2.5.1.6 Prepare and submit to the Bureau for review, corrective action plans for deficiencies within three (3) business days of identification.

A.2.2.5.1.7 Implement the Bureau-approved corrective action plans within agreed-upon time frames.

A.2.2.5.1.8 Make arrangements for the acceptance of all enrollment related records (e.g. benefit category change, address update, premium payment) from the current Facilities Manager for completion of processing after takeover.

A.2.2.5.1.9 No new enrollment or eligibility additions, deletions or updates are accepted by the current Facilities Manager during the final five (5) working days prior to the transfer date.

A.2.2.5.2 Contractor Deliverables for Assumption of TCMIS Functions

A.2.2.5.2.1 Provide a final operational readiness assessment to assure the ability of the Contractor to operate the TCMIS according to the requirements specified in the Contract.

A.2.2.5.2.2 Conduct training for Bureau staff.

A.2.2.5.2.3 Perform a file reconciliation with the records of the prior Facilities Manager to verify accurateness of all transfer of data after lock-down of related functional area activities, (e.g. eligibility, enrollment, claims, premiums, TPL).

A.2.2.5.2.4 Provide results of file reconciliation to Bureau staff.

A.2.2.5.2.5 Transfer all data and files to the Contractor.

A.2.2.5.2.6 Identify and report any implementation issues to the Bureau, document and place information online in the documentation repository.

A.2.2.5.2.7 Within five (5) days of the date of transfer from the prior Facilities Manager to the Contractor, the Bureau, the Contractor and outside stakeholders will specify the data exchange requirements with external resources for continuous processing and make arrangements for the acceptance of all receipts, (e.g. claim-related and pending claims) from the prior Facilities Manager for completion of processing after takeover.

A.2.2.5.2.8 Provide issue resolution documentation of outstanding issues.

A.2.2.5.3 Bureau Responsibilities

A.2.2.5.3.1 Approve assessment from Contractor that system is operation-ready.

A.2.2.5.3.2 Oversee final transfer of all data, including, but not limited to, eligibility and claims data.

A.2.2.5.3.3 Provide staff time to attend training sessions conducted by the Contractor for Bureau personnel.

A.2.2.5.3.4 Coordinate the termination or assumption of leases of TCMIS hardware and software.

A.2.2.5.3.5 Ensure that business associates terminate communications with prior Facilities Manager, and recommence with Contractor (e.g. print vendors, data exchange contacts).

A.2.2.5.3.6 Work with prior Facilities Manager on remaining transition/turnover tasks.

A.2.2.5.3.7 Work with Contractor to establish corrective action plans if implementation or reprocurement activities fall behind schedule or fail.

A.2.2.5.3.8 Review and approve Contractor-prepared corrective action plans for production fixes, performance issues, and enhancement defects.

A.2.3 Operational Readiness

As part of the TennCare Management Information System (TCMIS) Reprocurement Contract, an operational readiness test plan is required for the transition and implementation of the Facilities Manager operations (Section A.2.2.2.7). The Operational Readiness Test is designed to ensure that the Contractor and Bureau of TennCare staff are ready to process all inputs, correctly generate outputs, meet all reporting requirements, utilize a properly functioning data communications network, and have a demonstrated back-up capacity. The Contractor also must assess the operational readiness of Bureau staff that performs activities relating to the functions of document imaging, customer service, correspondence management, claims processing, eligibility and enrollment processing including managed care, drug rebate, financial operations, quality assurance, fraud and abuse oversight, processing for grievances and appeals, generating and storing notices, and providing data for analytical purposes. Operational readiness testing must include demonstrations, load testing and results, staff readiness testing, and communications testing.

Operational readiness testing will include all operational functions, as well as a volume test of several days of production capacity claim record volumes to demonstrate the TCMIS and the Contractor's staff are prepared for full production. The production volume testing will execute all TCMIS cycles – daily, weekly, monthly, quarterly, annually, and on-demand. The operational readiness test weekly cycle shall use at least a full week of operational data, and the monthly cycle shall use a minimum of two (2) weeks of operational data. Operational readiness testing may include a pilot test of actual claims processing in a full operational environment starting with the submission of electronic data interface (EDI) transactions into the translator through the payment process, including, but not limited to, document imaging, check request, issuance, and check/remittance advice mailing process (both electronically and on paper).

The testing of all other operational functions, including, but not limited to, enrollment and eligibility processes (such as notices, recipient demographic changes and capitation processing), will also be done. The addition, deletion and updating of enrollment records testing will include, but not be limited to, a recipient change of address, a new recipient add and a capitation payment made to an MCC. Also, a volume test of several days of production capacity eligibility files from DHS will be processed and will include the various eligibility interface file formats, such as 1610, ACCENT, Referrals, SSI and DCS. The enrollment and eligibility processes will be tested from transaction receipt of the DHS interfaces through processing EDI transactions (e.g. 834's, 820's, 271U's) with the MCCs.

An additional component of the operational readiness test is the demonstration and verification of data security and fire/disaster prevention and recovery procedures. The disaster recovery processing portion of the operational readiness test will be limited to a recovery during a daily and a weekly process cycle. The length of the test will be the amount of time that is necessary to recover from the disaster and provide proof that the recovery has been successfully completed.

The Contractor shall perform specific implementation and operations functions to ensure operational readiness. In preparation for operations, the Contractor will perform final file conversions (if needed for enhancements), recruit and train operations staff, and conduct any necessary training to providers and Bureau staff and their designees. The Bureau will review and approve the operational readiness test, systems and user documentation. The detailed requirements for operational readiness should include, but not be limited to, those listed below.

A.2.3.1 Contractor Requirements

A.2.3.1.1 Weekly written status reports shall be submitted on the progress of tasks against the transition Work Plan.

A.2.3.1.2 Conduct weekly status meetings with the Bureau's TCMIS Project Manager and other Bureau staff.

A.2.3.1.3 Inform the Bureau's TCMIS Project Manager of delays or setbacks to the critical path or project timeline by close of business on the day that any such issue or problem is identified.

A.2.3.1.4 Revise the transition project Work Plan, as necessary and approved by the Bureau, to provide current information regarding activities and dates.

A.2.3.1.5 Review progress and compliance with transition project plan.

A.2.3.1.6 Submit an updated staffing plan for all phases of the transition.

A.2.3.1.7 All staff should be submitted and approved to the Contract Compliance Unit; include information such as Name, RACF, Phone, Location, Manager and Position Code.

A.2.3.1.8 Revise the report distribution schedule to reflect updated Bureau decisions on format, media, and distribution.

A.2.3.1.9 Conduct a formal readiness walkthrough with the Bureau, to prove that all functional areas are ready.

A.2.3.1.10 Establish all test plans to be approved by the Bureau.

A.2.3.1.11 Develop procedures and supporting documentation for testing.

A.2.3.1.12 Establish test schedules with Bureau staff.

A.2.3.1.13 Provide appropriate Contractor staff for data examination and resolution during the testing.

A.2.3.1.14 Identify and resolve problems and discrepancies with Bureau or Bureau business partners.

A.2.3.1.15 Perform tests of the modified system or enhancement with input from current operations.

A.2.3.1.16 Compare the results with runs from the modified system to identical runs on the current system, if available, and provide the Bureau with detailed information resulting from the comparison.

A.2.3.1.17 Analyze and record test results.

A.2.3.1.18 Identify, generate, and provide test data as needed and in formats specified by the Bureau.

A.2.3.1.19 Perform tests of reports from prior-cycle data to compare to existing reports for data integrity of the modified or enhanced system.

A.2.3.1.20 Resolve any discrepancies in the TCMIS (e.g. source code, documentation)

identified as a result of testing. If defect is not corrected before system goes into production, monitor until resolved.

A.2.3.1.21 The Contractor will conduct comprehensive system testing for all functional areas to ensure that the TCMIS is processing correctly, prior to implementation of new Facilities Manager operations. Testing will be conducted utilizing applicable input files as specified by the Bureau.

A.2.3.1.22 Prepare a final Operational Readiness Assessment Document, including results of all testing and an assessment of the final operational readiness of Contractor staff to operate the TCMIS. The report will also certify that the TCMIS, its subsystems, functions, processes, operational procedures, staffing, telecommunications, and all other associated support is in place and ready for operation.

A.2.3.1.23 Revise systems and user documentation as required to fully describe system operation, and any modifications or enhancements.

A.2.3.1.24 Conduct orientation and training for Bureau personnel on Contractor organization, functional responsibilities, and operational procedures.

A.2.3.1.25 Establish an operational plan.

A.2.3.1.26 Implement operational plan.

A.2.3.1.27 Make arrangements for the acceptance of all claim-related receipts and pending claims from the prior Facilities Manager for completion of processing after takeover.

A.2.3.1.28 Work with prior Facilities Manager to not accept any new claims, either electronic or hard copies, during the final five (5) working days prior to the Contractor takeover date.

A.2.3.1.29 Allow for the complete resolution of all edits and adjudication of claims by the current Facilities Manger.

A.2.3.1.30 Identify and report any implementation issues to Bureau.

A.2.3.1.31 Process, from claims receipt to final disposition through the payment request process, in a fully operational environment, a representative sample of actual or test claim records, as designated by the Bureau, as an operational readiness test.

A.2.3.1.32 Identify necessary modifications to manual and automated operating procedures. Revise operating procedures as required.

A.2.3.1.33 Make arrangements for the acceptance of all enrollment related records (e.g. benefit category change, address update, premium payment) from the prior Facilities Manager for completion of processing after takeover.

A.2.3.1.34 Work with prior Facilities Manager to not accept any new enrollment or eligibility additions, deletions or updates during the final five (5) working days prior to the transfer date.

A.2.3.1.35 Perform a recipient reconciliation with prior Facilities Manager’s records to verify

accurateness of enrollment and eligibility data after lock-down of enrollment and eligibility related activity.

A.2.3.1.36 Process, from receipt (of eligibility update records) to final disposition through the enrollment process, in a fully operational environment, a representative sample of actual or test enrollment records, as designated by the Bureau, as an operational readiness test.

A.2.3.2 Contractor Deliverables

The Contractor Deliverables for Operational Readiness will be:

A.2.3.2.1 Revised Operating Procedures;

A.2.3.2.2 Training Plan;

A.2.3.2.3 Work Plan;

A.2.3.2.4 Status Reports;

A.2.3.2.5 Report distribution schedule;

A.2.3.2.6 Test plans and schedules;

A.2.3.2.7 Operational readiness test plans and schedules;

A.2.3.2.8 Updated staffing plan for operations;

A.2.3.2.9 Begin parallel testing;

A.2.3.2.10 Initial Operational Readiness Assessment and presentation to the Bureau;

A.2.3.2.11 Final Operational Readiness Assessment and presentation to the Bureau;

A.2.3.2.12 Conclude parallel testing;

A.2.3.2.13 Takeover Implementation of Operations;

A.2.3.2.14 Initial Assessment of Implementation success and presentation to the Bureau; and

A.2.3.2.15 Assessment of Implementation success and presentation to the Bureau.

A.2.4 Design, Develop, Implement, and Operate Enhancements

This section describes the System Enhancements of the TCMIS Reprocurement and Facilities Manager services. The Bureau of TennCare is seeking specific enhancements to the TCMIS with the constraint that the enhancements not jeopardize the transition schedule of the TCMIS or negatively impact the first days of operation under this Contract. Each enhancement must be managed according to the project management guidelines described in Section A.1. Additionally, each enhancement must be developed and implemented through a standard System Development Life Cycle (SDLC) that will 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 will select the final enhancements to be made to the TCMIS based on budget and schedule considerations.

A.2.5 Professional Staffing Requirements for Enhancements

For each of the TCMIS Enhancements, the Contractor must 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 must have administrative responsibility over the Enhancements to assure their proper coordination and compatibility with the existing TCMIS and ongoing operations.

The Bureau must 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. All key personnel shall be employed full-time at the Contractor's local site from their start date throughout the Enhancement processes. Resumes for all key personnel not identified in the Contract shall be approved in writing by the Bureau prior to the required start date for the position. The Bureau will be provided up to thirty (30) days to approve the position after receipt of the resumes. Personal interviews with these individuals may be required prior to Bureau approval of start of work, at the Bureau's option.

The Enhancement Project Manager's general responsibilities:

> This person will be the primary point of contact with the Bureau's TCMIS Project Manager 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 is also responsible for validating enhancement requirements and managing the completion of the design changes and deliverables through coding and testing. This position is further responsible for Contractor activities during acceptance testing of the enhancements. The Enhancement Project Manager shall be employed full-time at the Facilities Manager's Tennessee location.

A.2.6 Location of Enhancement Functions

All enhancement activities shall be performed in the same location and with the same space requirements as in Section A.2.2.2.5. Specific exceptions are: off-site programming support may be used for the enhancements; and an off-site conference room may be required to accommodate Bureau users, consultant staff, and Contractor staff during the requirements definition sessions, structured walk-throughs, acceptance testing tasks, and other activities that may be specific to the Enhancement Phase.

The Contractor must provide hardware (e.g. workstations), office equipment and space for Bureau staff use during the Enhancement Phase, for review and testing of Enhancement changes. Compliance with these minimum requirements is subject to review and approval by the Bureau.

A.2.7 Enhancement Process

The tasks associated with the development and implementation of each system enhancement shall be listed in the Facilities Management Enhancement Responsibilities (refer to A.2.9) 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 will 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 will vary. Each step may not be applicable to each enhancement. The Bureau and the Contractor will 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 must 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 will change certain functions or subsystems, but the TCMIS should 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 CMS. The Contractor is 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.2.8 Enhancement Implementation Timeline

The timeline to implement the major Enhancements depends on the selected Contractor. If the prior Facilities Manager is the successful Contractor, enhancements may begin immediately after Contract award and selection, but no later than three (3) months after the Contract start date. If a new Contractor is selected, a transition period to migrate the TCMIS to the new Contractor's facility and to test and stabilize production operations will be necessary before the new Facilities Manager will begin development of the enhancements. In this case, the new Contractor may begin the enhancements within three (3) months of the Contract start date, but no later than six (6) months of the Contract start date. The Contractor will be required to derive, and submit for approval by the Bureau, a schedule 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, assuming a January 11, 2008 Contract start date:

Enhancement #1 – Capability Maturity Model Integration (CMMI) – This Enhancement requires the Facilities Manager Contractor to lead the effort in raising the TennCare capability maturity level to level two (2) within twenty-four (24) months of the Contract start date and to level three (3) within twenty-four (24) months of being appraised at level two (2). The Contractor shall assess the current level, then plan, schedule, and implement the improvements necessary to reach CMMI level two (2). Appraisal of CMMI level shall be arranged by the Contractor and carried out by an independent third party. Once appraised of having reached CMMI level two (2), the Contractor shall begin the process of reaching CMMI level three (3).

Enhancement #2 – Claim Check Rules Software – Use McKesson's ClaimCheck to check claims rules and validate encounter claims processing accuracy. Testing, Bureau acceptance and implementation must be completed by January 1, 2009, or the date the Facilities Manager Contractor becomes fully operational.

Enhancement #3 – Project Management Office (PMO) – This Enhancement requires the Facilities Manager 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 must begin within two (2) months of Contract start date, and be completed and fully operational by March 31, 2008.

Enhancement #4 – COTS Dashboard – This Enhancement is to establish the use of Crystal Xcelsius, a COTS dashboard software product (such as Crystal Xcelsius), that will be used to report performance metrics and operations indicators. The Contractor must complete testing, obtain Bureau approval, and implement this Dashboard software by January 1, 2009, or the date the Contractor becomes fully operational.

Enhancement #5 – COTS Documentation Software – The Contractor must 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 must be fully tested, Bureau approved, and implemented by thirty (30) days prior to the Facilities Manager Contractor assuming operations.

Enhancement #6 – Enhanced Testing Environment – 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 will require four (4) new test environments. The Contractor must convert model office to the full systems test environment and the User Acceptance Test environment must be converted to the regression test environment. This is to be implemented and fully operational by January 1, 2009, or the date the Facilities Manager Contractor becomes fully operational.

Enhancement #7 – Business Process Modeling – This Enhancement requires the Facilities Manager to develop a complete and detailed business process model of the Bureau of TennCare and Contractor business processes, and that this process modeling shall include Activity Based Costing. The Contractor must complete all process documentation by June 30, 2009, and should begin at least a year in advance to ensure completion of this enhancement.

A.2.9 Facilities Manager Enhancement Responsibilities

The Contractor must 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 must be consistent with the proposed TCMIS project schedule and Deliverable Timetable. Specifically, the Contractor will be required to implement the system enhancements that the Bureau selects as described in Section A.2.10-A.2.16. The time frame for completion of the enhancements may demonstrate a phased approach to implementing the enhancements.

A.2.9.1 Contractor Requirements

A.2.9.1.1 Meet with Bureau staff to discuss any details or issues related to the definition of enhancements, schedule for development, and implementation approach.

A.2.9.1.2 Obtain Bureau approval for each Enhancement Phase Work Plan.

A.2.9.1.3 Conduct a requirements analysis process for each enhancement.

A.2.9.1.4 Identify all necessary interface requirements with outside parties and systems.

A.2.9.1.5 Document the requirements for review and approval by the Bureau.

A.2.9.1.6 Develop detail system design or program specifications, with Bureau approval.

A.2.9.1.7 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.2.9.1.7.1 Develop and implement test plan progress measurement metrics for the purpose of monitoring system test and integration/regression test status.

A.2.9.1.7.2 Update and maintain the metrics on a weekly basis.

A.2.9.1.7.3 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.2.9.1.7.4 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.2.9.1.8 Code modifications for the enhancements according to the approved specifications and the system design plan.

A.2.9.1.9 Prepare updated systems and operational documentation.

A.2.9.1.10 All systems and operational documentation must be verified and approved by

Contractor documentation management and quality assurance staff prior to submission to the Bureau.

A.2.9.1.11 Perform system tests and an integrated test of all system enhancements, improvements, and existing TCMIS processing, including system and regression testing.

A.2.9.1.12 Utilize the separate test environments created in Enhancement #6 to support the Bureau's user acceptance test effort.

A.2.9.1.13 Provide training to the acceptance testing team on preparing input data, using TCMIS screens, understanding TCMIS processes, and reviewing TCMIS outputs.

A.2.9.1.14 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.2.9.1.15 Provide operations staff to support acceptance test activities.

A.2.9.1.16 Finalize the implementation schedule based on Bureau approval.

A.2.9.1.17 Obtain Bureau approval for the updated systems and operational documentation.

A.2.9.1.18 Obtain Bureau approval for the implementation of each enhancement and system improvement.

A.2.9.1.19 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.2.9.1.20 Whenever JAD or JAR sessions are needed, provide a facilitator to conduct these sessions.

A.2.9.2 Contractor Deliverables

A.2.9.2.1 Prepare and submit to the Bureau an Enhancement Work Plan and Schedule for each Enhancement, including any updates.

A.2.9.2.2 Conduct Joint Application Design (JAD) sessions for each Enhancement to ensure the requirements definition and analysis supports the Bureau's business processes.

A.2.9.2.3 Report to Bureau any business process re-engineering needed by either the Bureau or the Contractor for each Enhancement.

A.2.9.2.4 Submit a Requirements Analysis Document for each Enhancement

A.2.9.2.5 Submit a Design document for each Enhancement

A.2.9.2.6 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.2.9.2.7 Testing reports shall be supplied weekly for as long as testing is in progress, for a given week and cumulatively to-date.

A.2.9.2.8 Create System Test Plan for each Enhancement, including testing responsibilities.

A.2.9.2.9 Create revised System and User Documentation incorporating each Enhancement.

A.2.9.2.10 Perform system testing for each Enhancement.

A.2.9.2.11 Create Integrated System Test Plan for each Enhancement.

A.2.9.2.12 Perform integrated system testing incorporating each Enhancement.

A.2.9.2.13 Distribute integrated system test results for each Enhancement.

A.2.9.2.14 Report Integrated System Test Progress Measurement Metrics incorporating each Enhancement.

A.2.9.2.15 Submit a Conversion Plan for each Enhancement, if required.

A.2.9.2.16 Submit Conversion Results for each Enhancement, if required.

A.2.9.2.17 Create and maintain a Problem Log Tracking Plan for each Enhancement.

A.2.9.3 Bureau Responsibilities

A.2.9.3.1 Determine priority for Contractor's Enhancement activities.

A.2.9.3.2 Be available to the Contractor for consultation in the development of a detailed requirements analysis on changes.

A.2.9.3.3 Review and approve the detailed design for changes.

A.2.9.3.4 Monitor system modification activities in conjunction with other ongoing TCMIS changes.

A.2.9.3.5 Perform Bureau decision-making and review activities for the Enhancements

(e.g. define and add the rules for the ClaimCheck software enhancement).

A.2.9.3.6 Review and approve Enhancement Work Plans and Schedules.

A.2.9.3.7 Assist in creating test scenarios.

A.2.9.3.8 The Bureau will be involved in all testing tasks and will use the Test Deliverables to evaluate testing progress.

A.2.9.3.9 Attend and participate in JAD sessions for Enhancement requirements.

A.2.9.3.10 Review Requirements Analysis and System Design Documents.

A.2.9.3.11 Review System Test Plans for each Enhancement, including testing responsibilities.

A.2.9.3.12 Review System and User Documentation.

A.2.9.3.13 Review Enhancement system testing.

A.2.9.3.14 Review integrated system testing incorporating Enhancement.

A.2.9.3.15 Assist in the development of test cases.

A.2.9.3.16 Review and approve updates to system documentation, only after the Contractor's documentation management and quality assurance staff has reviewed and approved it.

A.2.9.3.17 Review and approve updates to user documentation, operations procedures and procedure manuals; only after the Contractor's documentation management and quality assurance staff has reviewed and approved it.

A.2.9.3.18 Approve implementation of an enhancement prior to its installation and implementation into the TCMIS.

A.2.10 Enhancement #1 – Quality Improvement – CMMI

A.2.10.1 Summary

As part of the TennCare Management Information System (TCMIS) Reprocurement, 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 Facilities Management Contractor to adopt Capability Maturity Model Integration (CMMI) for their Bureau of TennCare 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 Facilities Management Contractor. The Contractor must get appraised at both CCMI for Development and CMMI for Services, once CCMI for Services is available.

A.2.10.2 System Functionality Contractor Requirements

A.2.10.2.1 The Contractor must utilize software, including source code and version control software upgrades, to achieve Standard CMMI Appraisal Method for Process Improvement (SCAMPI) Class A appraisal at Maturity Level 2 and 3 of CMMI for Development and CCMI for Services.

A.2.10.3 Business Process Functionality Contractor Requirements

A.2.10.3.1 The Contractor must 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.2.10.3.2 The Contractor must 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 implementation date of the Bureau of TennCare account.

A.2.10.3.3 While maintaining Maturity Level 2, or the appraised level from requirement A.2.10.3.2, of CMMI for Development, the Contractor must 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.2.10.3.4 The Contractor must 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 of TennCare account, or within twenty-four (24) months of the availability of CCMI for Services, whichever is sooner.

A.2.10.3.5 While maintaining Maturity Level 2, or the appraised level from requirement A.2.10.3.4, of CMMI for Services, the Contractor must 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.2.10.3.6 The Contractor must ensure the continuity of on-going business processes before, during and after attaining CMMI levels 2 and 3 for Development and Services.

A.2.10.4 Contractor Deliverables

A.2.10.4.1 Creation of Quality Improvement unit.

A.2.10.4.2 Appraisal at Maturity Level 2 of version 1.2, or the most current version, of CMMI for Development and CMMI for Services.

A.2.10.4.3 Appraisal at Maturity Level 3 of version 1.2, or the most current version, of CMMI for Development and CMMI for Services.

A.2.10.4.4 Training Plan

A.2.10.4.5 Project Management Plan

A.2.10.4.6 Communications Plan

A.2.10.4.7 Process Gap Analysis

A.2.10.4.8 Process Improvement Plan

A.2.10.4.9 Status Reports

A.2.11 Enhancement #2 – Claim Check Rules Software

A.2.11.1 Summary

The Facilities Manager Contractor must acquire McKesson's ClaimCheck COTS (Commercial Off-The-Shelf) claims check rules and enhanced encounter data validation software for the TennCare Management Information System (TCMIS). The TCMIS processes both fee-for-service (FFS) claims and encounter claims, and currently has encounter edits. However, these edits are difficult to change and the Bureau of TennCare does not have a fee-for-service processing research unit to develop guidelines pertaining to claims processing. Utilizing McKesson's ClaimCheck, a comprehensive claims auditing solution, will enable the TCMIS to support payers proper reimbursement by automatically evaluating claims, via sophisticated clinical logic, before reimbursement.

A.2.11.2 System Functionality Contractor Requirements

A.2.11.2.1 The Contractor must modify the TCMIS to add ClaimCheck functionality to perform sophisticated claims editing and auditing against current and historical records to identify incidences of improper coding.

A.2.11.2.2 The Contractor must support correct coding functionality which includes, but is not limited to:

A.2.11.2.2.1 The detection and correct processing of bundled/unbundled and duplicate claims;

A.2.11.2.2.2 Auditing of procedures and modifiers to detect incidental, mutually exclusive, and other improper coding conditions;

A.2.11.2.2.3 Editing process where procedure codes will be identified that should be denied with an explanation of denial code action; and

A.2.11.2.2.4 Editing process will work within the TCMIS for both fee-for-service (FFS) claims, which will get denied, and encounters, which will get edited.

A.2.11.2.3 Examples of the types of editing to be included are:

A.2.11.2.3.1 New visit frequency;

A.2.11.2.3.2 Incidental procedures for surgical procedures;

A.2.11.2.3.3 Pricing of multiple surgeries and multiple modifiers;

A.2.11.2.3.4 Add on codes from multiple surgery editing;

A.2.11.2.3.5 Mutually exclusive procedures;

A.2.11.2.3.6 Diagnosis to procedure editing;

A.2.11.2.3.7 Cross provider editing for surgeons and assistant surgeons;

A.2.11.2.3.8 Rebundling of procedures where procedure codes have been billed separately;

A.2.11.2.3.9 Pre-operative and post-operative services which should be included in the global surgery procedure;

A.2.11.2.3.10 Historical record check;

A.2.11.2.3.11 Convenience items;

A.2.11.2.3.12 Modifier auditing; and

A.2.11.2.3.13 Application of American Medical Association (AMA) guidelines as defined in the CPT for starred (*) procedures.

A.2.11.2.4 The Contractor must include the following functions, at a minimum, with the ClaimCheck functionality:

A.2.11.2.4.1 Line by line auditing, both online and batch, to ensure the correct reimbursement value for each claim line.

A.2.11.2.4.2 Consistent application of payment guidelines across all claims processed.

A.2.11.2.4.3 Automate parts of the clinical review process to reduce claims handling costs.

A.2.11.2.4.4 Customizable audit criteria and relational audits to monitor appropriateness, questionable claims and assist with medical management issues.

A.2.11.2.4.5 Pricing and payment evaluations performed on at least three (3) data elements per relationship (e.g. procedure code, diagnosis code, and provider type).

A.2.11.2.4.6 Customizable reporting that displays, at a minimum, daily activity, actual dollars, accounts receivables from denials and suspended claims.

A.2.11.2.4.7 Security to limit access to only authorized users to meet HIPAA requirements.

A.2.11.3 Business Process Functionality Contractor Requirements

A.2.11.3.1 The Contractor must implement a fully automated pre- and post-payment auditing system using McKesson's ClaimCheck, while providing support and guidance relative to the implementation of the ClaimCheck software.

A.2.11.3.2 The Contractor must maintain the ClaimCheck software.

A.2.11.3.3 The Contractor must correctly customize the ClaimCheck software, as requested in writing by the Bureau of TennCare.

A.2.11.3.4 The Contractor must provide reporting for ClaimCheck software including, but not limited to, correctly producing and delivering reports on enhanced claims editing online and/or via other media specified by the Bureau on an agreed upon schedule.

A.2.11.3.5 The Contractor must correctly apply/upgrade to the most current version of ClaimCheck, as approved in writing by the Bureau of TennCare.

A.2.11.3.6 The Contractor must integrate the ClaimCheck software with interChange.

A.2.11.3.7 The Contractor must ensure the continuity of ongoing business processes before, during and after implementation of the ClaimCheck software.

A.2.11.3.8 The Contractor must develop a Detail System Design (DSD), User Manual, Operations Manual and Training Manual for the Claim Check software.

A.2.11.4 Contractor Deliverables

A.2.11.4.1 Procurement of McKesson's ClaimCheck software

A.2.11.4.2 Implementation of McKesson's ClaimCheck software

A.2.11.4.3 Customization for TennCare of McKesson's ClaimCheck software

A.2.11.4.4 Integration with interChange of McKesson's ClaimCheck software

A.2.11.4.5 Detail System Design

A.2.11.4.6 User Manual

A.2.11.4.7 Operations Manual

A.2.11.4.8 Training Manual

A.2.11.4.9 Testing and Bureau acceptance of McKesson's ClaimCheck Functionality

A.2.11.4.10 Completion and Implementation of Enhancement #2, installation of McKesson's ClaimCheck software.

A.2.12 Enhancement #3 - Project Management Office

A.2.12.1 Summary

The Bureau of TennCare 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 will 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.2.12.2 Contractor PMO Deliverables

A.2.12.2.1 Establish Project Management Office

A.2.12.2.1.1 The Contractor shall establish a Project Management Office which shall contain staff to develop and facilitate the necessary PMO methodologies, policies and procedures;

A.2.12.2.1.2 Institute policies, processes and procedures for management of PMO;

A.2.12.2.1.3 The Contractor must maintain the PMO to oversee all TCMIS projects and ongoing system functionality.

A.2.12.2.1.4 The Contractor must have procedures in place that make certain all requirements for Project Management are met.

A.2.12.2.1.5 Project Managers must be certified as a Project Management Professional (PMP) or have equivalent experience.

A.2.12.2.2 Develop and Implement Processes to Control Scope of Work

A.2.12.2.2.1 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 the Contract. In the event that the scope dispute procedure determines that work required by the Bureau is beyond the scope of work covered by the Contract, the change management process will be used to describe, quantify, and approve any additional tasks.

A.2.12.2.3 Develop and Implement Other Processes to Oversee the Work Performed

A.2.12.2.3.1 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.2.12.2.3.2 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.2.12.2.4 Develop Earned Value Management System (EVMS) Metrics

A.2.12.2.4.1 The Contractor must 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 method and formulas for calculation of EVMS must be reviewed and approved by the Bureau prior to use on the project.

A.2.12.2.5 Develop an Operations Management Plan

A.2.12.2.5.1 The Contractor shall develop a comprehensive Operations Management Plan for review and approval by the Bureau. The plan must address how the Contractor will manage day-to-day Facilities Manager Operations.

A.2.12.2.6 Implementation of Project Management Office Operations

A.2.12.2.7 Project Charter Documentation, Refer to Section A.2.12.4.4

A.2.12.2.8 Stakeholder Analysis Documentation – Refer to Section A.2.12.4.5

A.2.12.2.9 Project Status Reporting Documentation – Refer to Section A.2.12.4.15

A.2.12.2.10 Requirements Analysis Documentation – Refer to Section A.2.12.4.16

A.2.12.2.11 Business Design Documentation – Refer to Section A.2.12.4.17

A.2.12.2.12 Technical Design Documentation – Refer to Section A.2.12.4.18

A.2.12.3 System Functionality Contractor Requirements

A.2.12.3.1 The Contractor must utilize Project Management software, such as Microsoft Project, as directed by the Bureau.

A.2.12.3.2 The Contractor must consolidate reports required for the management of projects by either integrated project management tools or COTS products.

A.2.12.3.3 The Contractor must develop or use a COTS correspondence management system to manage official correspondence between the Contractor and the Bureau. The system should be web-based and conform to MMIS architecture or State standards.

A.2.12.4 Business Process Functionality Contractor Requirements

A.2.12.4.1 The Contractor will create a Project Management Office (PMO) and will follow the Project Management Body of Knowledge (PMBOK) guidelines for managing a project.

A.2.12.4.2 The Contractor will coordinate Project Management activities with the Bureau's Project Management Office.

A.2.12.4.3 The Contractor PMO will 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 fifteen (15) full time equivalent (FTE) workdays of estimated effort;

Small Project - Any work task with sixteen (16) to twenty-nine (29) FTE workdays of estimated effort;

Medium Project - Any work task with thirty (30) to ninety (90) FTE workdays of estimated effort; and

Large Project - Any work task with more than ninety (90) FTE workdays of estimated effort.

A.2.12.4.4 Project Charter - The Contractor must provide a Project Charter for all projects. The project charter must 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.2.12.4.5 Stakeholder Analysis - The Contractor must 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.2.12.4.6 Communications Management Plan - The Contractor must provide a Communications Management Plan for all Projects. Early in the Project, the Contractor will determine all Bureau communications needs, including status reporting and project monitoring, and create a process to meet those needs. During the project, the Contractor will 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 will meet with the Bureau to receive quality improvement feedback, and will record lessons learned for use in future Projects.

A.2.12.4.7 Work Breakdown Structure - Early in every Project, the Contractor will perform scope planning and scope definition tasks to result in a Work Breakdown Structure (WBS), known informally as the Project Plan. This WBS must identify and record all major tasks, milestones and deliverables associated with the Project. The work must 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 must be further decomposed. During execution of the project, the Contractor must measure performance according to the WBS and manage changes to the plan requested by the Bureau. When tasks are complete, the Contractor must seek verbal acceptance from the Bureau for each task, and formal acceptance of each deliverable.

A.2.12.4.8 Risk Management Plan - The Contractor must develop and use a standard Risk Management Plan approved by the Bureau for all Medium and Large Projects. The plan must address the process and timing for risk identification, describe the process for tracking and monitoring risks, identify the Contractor staff that will be involved in the risk management process, identify the tools and techniques that will be used in risk identification and analysis, describe how risks will be quantified and qualified, and how the Contractor will perform risk response planning. The Contractor must produce lists of identified risks and, for each risk, the Contractor must evaluate and set the risk priority based on likelihood the risk will occur and impact, assign risk management responsibility, and create a risk management strategy. For each significant accepted risk, the Contractor must develop risk mitigation strategies to limit the impact. The Plan must 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.2.12.4.9 Cost Management Plan - Early in every project, the Contractor must determine the resources necessary to complete the project in a timely and efficient manner, and must estimate and budget for costs, and post these estimates to each task in the WBS. Although in most cases the costs will not be chargeable to the Bureau, the estimate will be used by the Bureau for planning and setting priorities, and will be used by the Bureau and the Contractor to report cost variance. During execution of the project, the Contractor must 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.2.12.4.10 Quality Management Plan - The Contractor must employ a formal Quality Management Plan for each Large Project. Early in the Project, the Contractor must 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 must reflect a process for sampling and audits and for continuous quality improvement.

A.2.12.4.11 Staffing Management Plan - For all projects, the Contractor must create a Staffing Management Plan, including organizational charts with defined responsibilities and contact information. Resources must be allocated by name or by type to the WBS, and hourly rates must be listed for all assigned staff. Staff allotted to a project must remain on that project for the duration of the project. During project execution, the Contractor must provide appropriate training and management supervision to all staff.

A.2.12.4.12 Time Management and Project Schedule - For all projects, the Contractor must create a Project Schedule. The Project Schedule must 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.2.12.4.13 Project Execution and Control - During execution of every project, the Contractor must exert control to assure the completion of all tasks according to the Project Schedule and Project Budget. All variances must be reported to the Bureau, and the Contractor must work with the Bureau to address any variance in a manner to ensure overall completion of the Project within time and budget constraints. The Bureau will work with the Contractor to approve fast-tracking or reallocation of Contractor resources as necessary.

A.2.12.4.14 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 must execute careful change control on every project. The Contractor must develop or use a COTS correspondence management system to manage official correspondence between the Contractor and the Bureau. The system should be web-based and conform to MMIS architecture or State standards. All written and official electronic correspondence between the Contract Manager and the Contractor must be logged, archived and maintained by the Contractor for seven (7) years beyond the term of the Contract and any amendment(s) of the Contract. The Contractor must provide the Bureau with electronic access to this correspondence, including access to images of all written correspondence.

A.2.12.4.15 Project Status Reporting - For all projects, the Contractor must 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 will prepare:

A.2.12.4.15.1 A general status report;

A.2.12.4.15.2 Activities completed in the preceding period;

A.2.12.4.15.3 Activities planned for the next period;

A.2.12.4.15.4 A report on issues that need to be resolved;

A.2.12.4.15.5 A report on the status of risks, with special emphasis on change in risks, risk triggers, or the occurrence of risk items;

A.2.12.4.15.6 A report on the status of each task in the WBS that is in progress or overdue;

A.2.12.4.15.7 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.2.12.4.15.8 A schedule variance report showing the earned value of the work completed, the planned value of the work completed, and the variance.

A.2.12.4.15.9 Monthly and Quarterly Status reports will summarize data from the agreed upon interval (e.g. weekly) reports, include financial information related to expenses and billings and

A.2.12.4.15.10 Include executive summaries for presentation to management and oversight bodies.

A.2.12.4.16 Requirements Analysis Document - For all medium and large projects, the Contractor must develop a Requirements Analysis Document, which will include, but not be limited to, the following:

A.2.12.4.16.1 Executive Summary

A.2.12.4.16.2 Overview of all processes

A.2.12.4.16.3 Overview and purpose of all interfaces

A.2.12.4.16.4 Discussion of the design implications for each major element of the project

A.2.12.4.16.5 System designs or modifications necessary to complete the project

A.2.12.4.16.6 General report definitions

A.2.12.4.16.7 General screen definitions

A.2.12.4.16.8 System behavior model (user interfaces-free form)

A.2.12.4.16.9 High-level flowcharts

A.2.12.4.17 Business Design Document - For all medium and large projects, the Contractor must develop a Business Design Document, which will include, but not be limited to, the following:

A.2.12.4.17.1 Purpose and general business description of each program, module, screen, process, and report

A.2.12.4.17.2 Lists of inputs, outputs and interfaces

A.2.12.4.17.3 Process flowcharts

A.2.12.4.17.4 General resource requirements

A.2.12.4.18 Technical Design Document - For all medium and large projects, the Contractor must develop a Technical Design Document, which will include, but not be limited to, the following:

A.2.12.4.18.1 Hardware and software requirements, including Data Model changes

A.2.12.4.18.2 Program, screen and report specifications sufficient to begin programming and construction

A.2.12.4.18.3 Prototypes

A.2.12.4.18.4 Pseudo-code

A.2.12.4.18.5 Database design or change specifications

A.2.12.4.18.6 Data conversion and interface requirements

A.2.12.4.19 The Contractor must ensure the continuity of on-going business processes before, during and after creation of the PMO.

Table of Project Management Contractor Requirements Section A.2.12.4

This table lists the deliverables and contents that are 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	• Identification of Bureau &		X	X

Deliverable	Contents	Small Project	Medium Project	Large Project
Analysis	Contractor Executive Sponsor for the project • Identification of stakeholders • Stakeholder roles/interests/expectations • Stakeholder contact information • Establish lines of authority & reporting responsibilities			
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 • Resource allocation by task and role • Decompose so no task has estimated work effort more than eighty (80) hours	X	X	X
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 will 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
Cost Management Plan	• Determine necessary resources • Estimate and budget costs • Post estimates to WBS tasks • Report cost variance at task level	X	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 • Staff schedules		X	X

Deliverable	Contents	Small Project	Medium Project	Large Project
	• Staff contact information • Resource allocation by name or type to WBS			
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
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 Quarterly	• General status report • Completed activities • Planned activities • Project issues • Risk status • WBS task status • Cost variance report • Schedule variance report • Financial information • Executive summaries	X	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
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

Deliverable	Contents	Small Project	Medium Project	Large Project
Technical Design Document	• Hardware and software requirements • Program, screen and report specifications sufficient to begin programming and construction • Prototypes • Pseudo-code • Database design or change specifications • Data conversion (if needed), and interface requirements		X	X
On-going Operations	• The Contractor must ensure the continuity of on-going business processes before, during and after creation of the PMO.	X	X	X

A.2.12.5 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.2.12.5.1 PMO Processes, Policies and Procedures

A.2.12.5.2 Project Charter

A.2.12.5.3 Stakeholder Analysis

A.2.12.5.4 Communications Management Plan

A.2.12.5.5 Project Scope Statement

A.2.12.5.6 Project Plan

A.2.12.5.7 Risk Management Plan

A.2.12.5.8 Procedure and data sources for calculation of EVMS

A.2.12.5.9 Quality Management Plan

A.2.12.5.10 Staffing Management Plan

A.2.12.5.11 Detailed Work Plan and Project Schedule

A.2.12.5.12 Project Management Reports & Correspondence

A.2.12.5.13 Status Reports

A.2.12.5.14 Requirements Analysis Document

A.2.12.5.15 Business Design Document

A.2.12.5.16 Technical Design Document

A.2.12.5.17 Operations Management Plan

A.2.12.5.18 Training Manual

A.2.12.6 Bureau Responsibilities

Bureau responsibilities include the following:

A.2.12.6.1 Approve Contractor's PMO methodologies.

A.2.12.6.2 Coordinate projects with Contractor PMO.

A.2.13 Enhancement #4 – COTS Dashboard

A.2.13.1 Summary

The Facilities Manager Contractor must create dashboard metrics that shall have the capability to be customized by the TennCare Management Information System (TCMIS) users. Currently, the Bureau of TennCare 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 can turn data into an intuitive visual presentation and can model the future performance of TennCare programs through "what-if" analyses.

A.2.13.2 System Functionality Contractor Requirements

A.2.13.2.1 The Contractor must create the Dashboards to do the following:

A.2.13.2.1.1 Combine financial information with operational information to provide a complete view of performance.

A.2.13.2.1.2 Utilize data resources to present users with clear summary information.

A.2.13.2.1.3 Achieve performance insight through the strongest visual navigation and analysis tool.

A.2.13.2.1.4 Create with input from the Bureau, definitions of requirements to reduce design iterations and leverage proper metrics.

A.2.13.2.1.5 Update dynamically from live data and be available on the State intranet.

A.2.13.2.1.6 Track all performance indicators and penalties via the dashboard software.

A.2.13.2.1.7 The Contractor must 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.2.13.2.2 The Contractor must 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.2.13.2.3 The Contractor must incorporate the ability to report on and add indicators to the Dashboards, as determined by the Bureau.

A.2.13.2.4 The Contractor must use Crystal Xcelsius or similar COTS software, to create the Dashboards.

A.2.13.2.5 The Contractor must integrate the COTS Dashboard software with the TCMIS, including interChange Bureau SharePoint and Business Objects environment.

A.2.13.3 Business Process Functionality Contractor Requirements

A.2.13.3.1 The Contractor must 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.2.13.3.2 The Contractor must maintain the dashboard software as a data source that is updated hourly, daily, weekly, or monthly, as defined by the Bureau.

A.2.13.3.3 The Contractor must create Dashboards with key performance metrics, as specified in part 6.1.2.2.4 of Attachment 2 of the Contract defining the Dashboard Performance Metrics, which can be customized for each business user.

A.2.13.3.4 The Contractor must make Dashboards available to all appropriate staff, as defined by the Bureau.

A.2.13.3.5 The Contractor must be able to add Dashboard indicators, as requested by the Bureau.

A.2.13.3.6 The Contractor must ensure the continuity of on-going business processes before, during and after implementation of the Dashboard software.

A.2.13.3.7 The Contractor must develop a Detail System Design (DSD), User Manual, Operations Manual and Training Manual for the Dashboard software.

A.2.13.4 Contractor Deliverables

A.2.13.4.1 Procurement of Crystal Xcelsius, or similar Dashboard COTS software

A.2.13.4.2 Implementation of COTS Dashboard software

A.2.13.4.3 Customization for TennCare of COTS Dashboard software

A.2.13.4.4 Integration with interChange of COTS Dashboard software

A.2.13.4.5 COTS Dashboard Detail Design Document

A.2.13.4.6 COTS Dashboard User Manual

A.2.13.4.7 COTS Dashboard Operations Manual

A.2.13.4.8 COTS Dashboard Training Manual

A.2.13.4.9 Testing and Bureau acceptance of COTS Dashboard software

A.2.13.4.10 Completion and Implementation of Enhancement # 4, installation of COTS Dashboard software.

A.2.14 Enhancement #5 – COTS Documentation Software

A.2.14.1 Summary

The Facilities Manager Contractor must acquire 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). 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.2.14.2 System Functionality Contractor Requirements

A.2.14.2.1 The Contractor must secure documentation software that will retain prior versions of published documents, including Contractor work products and deliverables.

A.2.14.2.2 The Contractor must secure documentation software that will include content navigation capabilities (e.g. Content topology, hierarchy).

A.2.14.2.3 The Contractor must secure documentation software capable of containing content including, but not limited to:

A.2.14.2.3.1 Documentation User Manuals

A.2.14.2.3.2 COTS Documentation Quick Reference User Documents

A.2.14.2.3.3 Documentation Operations Manuals

A.2.14.2.3.4 Documentation Procedure Manuals

A.2.14.2.3.5 Documentation Training materials

A.2.14.2.3.6 Technical documentation including Configuration management

A.2.14.2.3.7 COTS Documentation Source code

A.2.14.2.3.8 Documentation Deliverables

A.2.14.2.3.9 COTS Documentation Test plans

A.2.14.2.3.10 COTS Documentation Test results

A.2.14.2.3.11 Performance metrics

A.2.14.2.3.12 Documentation standards

A.2.14.2.3.13 Requirements for the various types of documentation repository for all documentation related to the TennCare program.

A.2.14.2.4 The Contractor must secure documentation software that is searchable by subject matter.

A.2.14.2.5 The Contractor must secure documentation software that has keyword and soundex search capability.

A.2.14.2.6 The Contractor must secure documentation software that has web link integrity checking (to eliminate 'page not found' errors).

A.2.14.2.7 The Contractor must secure documentation software that has the ability to provide internal and external access via security levels.

A.2.14.2.8 The Contractor must secure documentation software that will allow for migration of existing documentation contained in current repositories (e.g. PWB) to the new solution.

A.2.14.2.9 The Contractor must secure documentation software that provides structured workflow (including review, revision and approvals) for production of all document deliverables and publication materials.

A.2.14.2.10 The Contractor must secure documentation software that is capable of electronic notification (e.g. broadcast emails) when content is revised or initially published to interested parties.

A.2.14.2.11 The Contractor must secure documentation software with twenty-four hours per day, seven days per week (24/7) availability and operability (fully functional) except for agreed upon scheduled maintenance periods.

A.2.14.2.12 The Contractor must secure documentation software that will integrate document imaging and workflow with the TCMIS procured under this Contract.

A.2.14.2.13 The Contractor must secure documentation software that provides a unique identifier for each entity, including version designation.

A.2.14.2.14 The Contractor must secure documentation software that will integrate functionality with the TeamTrack application.

A.2.14.2.15 The Contractor must secure documentation software that is capable of fully configurable access and security by individual, group, or requestor type.

A.2.14.2.16 The Contractor must secure documentation software that will integrate with interChange.

A.2.14.3 Business Process Functionality Contractor Requirements

A.2.14.3.1 The Contractor must 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.2.14.3.2 The Contractor must ensure the continuity of on-going business processes before, during and after implementation of the COTS documentation software.

A.2.14.3.3 The Contractor must 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.2.14.4 Contractor Deliverables

A.2.14.4.1 Procurement of Documentation software

A.2.14.4.2 Implementation of Documentation software

A.2.14.4.3 Customization for TennCare of Documentation software

A.2.14.4.4 Integration with interChange and TeamTrack of Documentation software

A.2.14.4.5 Documentation User Manual

A.2.14.4.6 Documentation Operations Manual

A.2.14.4.7 Documentation Training Manual

A.2.14.4.8 Testing and Bureau acceptance of COTS Documentation software

A.2.14.4.9 Completion and Implementation of Enhancement # 5, installation of COTS Documentation software

A.2.15 Enhancement #6 – Enhanced Testing Environment

A.2.15.1 Summary

Another enhancement is an enhanced testing environment to allow for multiple test environments. The current TCMIS testing environment consists of Model Office and UAT (User Acceptance Testing). The Model Office environment was utilized by the prior Facilities Manager for their Systems Integration Testing of any changes prior to review by the Bureau of TennCare staff. The UAT environment is used by the Bureau of TennCare staff as a user full system test environment to review any changes prior to being released into the production environment. 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 should 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 must facilitate the various levels of testing according to State standards.

a) Unit testing – develop environment for single unit tests

b) Integration testing – to test multiple parts of an integrated system

c) Fully integrated systems testing – for final acceptance that the change is correct

d) Regression testing – ensures other components have not been erroneously affected by the change

To facilitate emergency changes, (or high priority change requests) without interruptions, one (1) integrated test environment should be allocated for changes that must be quickly implemented

When a developer needs to make a change to a module that is already checked out and the change is an emergency change, the developer shall be allowed to check out a second copy of the module. The version control tool will remember that two (2) copies of the same module are checked out, by creating a branch when the second copy of the module is checked out.

The first of the two (2) modules checked out to two (2) developers will be allowed to be checked in as normal. When the second of the two (2) modules that were checked out to two (2) developers is checked in, the version control tool will stop the check-in process and require the two (2) modules to be merged. Merging is done manually.

Once the merge is completed, the module is checked back in. It will appear as a merged branch. It will be numbered as the latest version of that module. Any subsequent build will pick up the merged module. Any developer wishing to modify that module will check out the merged module.

Any build using the merged module will be built and tested normally.

A.2.15.2 System Functionality Contractor Requirements

A.2.15.2.1 The Contractor must provide, operate and maintain an enhanced testing environment to allow for four (4) integrated test environments, one (1) full system test environment, and one (1) regression test environment;

A.2.15.2.2 The Contractor shall ensure that multiple priorities can be tested simultaneously;

A.2.15.2.3 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.2.15.2.4 A User Acceptance Testing (UAT) environment is not specifically defined because the users will be coordinating the testing with the programmers during both the System testing and Integration testing. The enhanced test environment will include the following:

A.2.15.2.4.1 Create and Implement four (4) Integrated Testing Environments:

1) Eligibility/Enrollment
2) Claims/Encounters
3) Special Projects
4) Other

A.2.15.2.4.2 A Full System testing environment will be used to test the merged code from the integrated testing environments. Any change that fails testing in the full systems testing environment will be corrected and retested in the integration testing environment. Any changes that pass testing in the full systems testing environment will be promoted to the regression testing environment.

A.2.15.2.4.3 A Regression testing environment will be used for complete regression testing prior to moving changes into production and will 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.2.15.2.4.4 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.2.15.2.4.5 The Contractor shall allow for unique identification of test claims, test providers, and test enrollees.

A.2.15.2.4.6 Provide for an integrated testing environment that will accept changes to eligibility and enrollment that will then be tested and followed through a simulation of the production environment.

A.2.15.2.4.7 Provide and maintain an integrated testing environment that will process claims and encounters that will then be tested and followed through a simulation of the production environment.

A.2.15.2.4.8 Provide and maintain an integrated testing environment that will allow for complete testing of special projects.

A.2.15.2.4.9 Provide for an integrated testing environment that will allow for complete testing of other additional priorities.

A.2.15.2.5 The Contractor shall be required to use State standard testing tools beginning 01/01/2009, (or operations start date). This includes Serena® Builder and Version Manager.

A.2.15.2.5.1 The State may consider the use of other testing tools if the Contractor proves that the tools support all aspects of configuration management and are comparable to the Serena® Builder and Version management tools.

A.2.15.2.6 The Contractor must use version control procedures.

A.2.15.2.7 The Contractor must update schedules to facilitate tests.

A.2.15.2.8 The Contractor must track discrepancies.

A.2.15.2.9 The Contractor must facilitate regression test analysis.

A.2.15.2.10 The Contractor must 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.2.15.2.11 The Contractor must provide controls to maintain the integrity of the test data in the multiple testing environments.

A.2.15.2.12 The Contractor must 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.2.15.2.13 The Contractor must produce and review all control reports generated for each test update and processing cycle.

A.2.15.2.14 The Contractor must perform TCMIS testing through the following test levels in the order specified, unless exception is granted for emergency events:

1) Unit testing - done by developers in the development environment.

2) Integration testing - done by the State and the Contractor in the integration environments.

3) System testing (normal) – done by the State and the Contractor in the full system test environment.

4) Regression testing – done by the State and the Contractor to perform regression testing prior to releasing changes into production.

A.2.15.2.15 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.2.15.2.16 The Contractor must 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.2.15.3 Business Process Functionality Contractor Requirements

A.2.15.3.1 The Contractor must provide the capability and procedures to allow for multiple software modifications concurrently to include, at a minimum, the following:

A.2.15.3.1.1 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.2.15.3.1.2 Ensure that the multiple test environments will allow for different phases of testing to be conducted concurrently;

A.2.15.3.1.3 Assure accurate testing of maintenance and modifications;

A.2.15.3.1.4 Provide capability to link to a particular project and associate multiple existing projects;

A.2.15.3.1.5 Provide migration procedures for moving multiple projects into production involving common software modules; and

A.2.15.3.1.6 Update the system audit trail to ensure accurately promoting modified software for multiple projects.

A.2.15.3.2 The Contractor must 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.2.15.3.3 The Contractor must use the walk-through method for "walking through the material" with the Bureau, when requested. This method, when used for reviewing applications, can detect inconsistencies between the specifications and the application, Bureau standards and the application or within the application itself.

A.2.15.3.4 The Contractor must report on the impact of test cycles and compare those results to the actual processing results.

A.2.15.3.5 The Contractor must keep all test outputs separate from routine TCMIS outputs, and clearly label all outputs as test outputs.

A.2.15.3.6 The Contractor must produce and review all control reports generated for each test update and processing cycle.

A.2.15.3.7 The Contractor must develop test data, including, but not limited to, claims/encounter data and eligibility/enrollment data at the direction of the Bureau. The testing processes will include all forms of data submission (e.g. interactive, batch, data entry).

A.2.15.3.8 The Contractor must 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.2.15.3.9 The Contractor must 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.2.15.3.10 The Contractor must 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.2.15.3.11 The Contractor must create Test Plans for each application; one (1) for the project and one (1) for each level of testing. 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 will use. Industrial, Electrical and Electronic Engineers (IEEE), a standard setting organization, identifies the following as subjects to be addressed in a Test Plan:

A.2.15.3.11.1 Test Items

A.2.15.3.11.2 Features to be Tested

A.2.15.3.11.3 Features Not to be Tested

A.2.15.3.11.4 Testing Approach

A.2.15.3.11.5 Testing Item Pass/Fail Criteria

A.2.15.3.11.6 Suspension Criteria and Resumption Requirements

A.2.15.3.11.7 Test Deliverables

A.2.15.3.11.8 Testing Tasks

A.2.15.3.11.9 Environmental Needs

A.2.15.3.11.10 Responsibilities

A.2.15.3.11.11 Staffing Needs

A.2.15.3.11.12 Training Needs

A.2.15.3.11.13 Testing Schedule

A.2.15.3.11.14 Risks and Contingencies

A.2.15.3.11.15 Approvals for Testing

A.2.15.3.12 The Contractor must develop Test Management Plans that address management of the test process for the project and according to test plan standards.

A.2.15.3.13 A Test Management Plan must address each test environment individually, with sections for Unit Test Plan, System Test Plan, and Integration Test Plan.

A.2.15.3.14 A Test Management Plan must address the objectives, approach, procedures, and techniques used in each test environment.

A.2.15.3.15 A Test Management Plan must address the environment, including infrastructure safeguards, test condition level and format, source and management of test data, and test validation procedures.

A.2.15.3.16 A Test Management Plan must 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.2.15.3.17 A Test Management Plan must outline resource requirements that, at a minimum, include information pertaining to personnel, hardware, and testing tools.

A.2.15.3.18 The Contractor must develop Test Cases that document the preconditions (what relevant data must exist at the start of the test case execution), inputs, and the expected results.

A.2.15.3.19 The Contractor must provide a library of test cases that may be selected and modified by the user for testing.

A.2.15.3.20 The Test Case Library must have search capability that is cross referenced to the logic/edit that test case is designed to test.

A.2.15.3.21 The Test Case Library must 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.2.15.3.22 Test Documentation shall be reviewed and approved prior to testing.

A.2.15.3.23 The Contractor must record Test Results in a form that can be validated after the test case is executed.

A.2.15.3.24 Test Results shall be reviewed to verify correctness.

A.2.15.3.25 The Contractor must retain Test Documentation as long as the tested version of the application remains in production.

A.2.15.3.26 The Contractor must perform Unit Testing, which is dynamically testing all new or modified software units (e.g. modules, programs, job streams, scripts). Unit Test Results shall prove that the unit performs all specified functions correctly and maintains data integrity under all specified conditions.

A.2.15.3.27 Unit Test Results shall be recorded in a form that can be validated after the test case is executed.

A.2.15.3.28 The Contractor must develop a Unit Test Plan prior to unit testing.

A.2.15.3.29 The Unit Test Plan shall include, at a minimum:

A.2.15.3.29.1 Test conditions and expected results for the program's main functions;

A.2.15.3.29.2 Test cases;

A.2.15.3.29.3 Preconditions, both expected and unexpected (what relevant data exists at the start of the test case execution);

A.2.15.3.29.4 Inputs (both valid and invalid);

A.2.15.3.29.5 Boundary conditions such as loop exit criteria;

A.2.15.3.29.6 Expected results for test cases and units;

A.2.15.3.29.7 Unit Test Documentation (e.g. plans, input data, execution scripts); and

A.2.15.3.29.8 Test results that shall be retained as long as the tested version of the module remains in production.

A.2.15.3.30 The Contractor must develop an Integration Test Plan prior to integration testing according to test plan standards.

A.2.15.3.31 The Contractor must perform System Tests on all new and significantly modified applications and verify before release of the application to the Bureau.

A.2.15.3.32 System tests shall prove that the application functions correctly as integrated.

A.2.15.3.33 System Tests for any functionality shall be completed before regression testing for that functionality begins.

A.2.15.3.34 The Contractor must develop a System Test Plan prior to system testing according to test plan standards. System Test Results shall be recorded in a form that can be validated after the system test case is executed.

A.2.15.3.35 The Contractor must 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.2.15.3.36 The Contractor must 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 must mirror production in its files, databases, processing, and reporting. The full system and regression test environments must allow for end-to-end testing, (e.g. from claims entry through the financial and reporting cycles). The user acceptance testing will be incorporated into the integration, full system, and regression testing environments.

A.2.15.3.37 The Contractor must provide the ability to execute impact analysis testing of any proposed change.

A.2.15.3.38 The Contractor must provide the ability to create “what-if” scenarios and compare results between scenarios in a test environment.

A.2.15.3.39 The Contractor must provide testing environments that allow users to create and edit provider, recipient, and health plan records for testing.

A.2.15.3.40 The Contractor must ensure the continuity of on-going business processes before, during and after implementation of the enhanced test environment.

A.2.15.4 Contractor Deliverables

A.2.15.4.1 Establish enhanced test environments

A.2.15.4.2 Customize enhanced test environments for TennCare

A.2.15.4.3 Integrate enhanced test environments with interChange

A.2.15.4.4 Implement source code control and version control software in the enhanced test environment

A.2.15.4.5 Acquire Bureau acceptance and approval of output produced from the multiple test environments

A.2.15.4.6 Facilitate Bureau online access to the multiple testing environments

A.2.15.4.7 Acquire Bureau acceptance and approval of control reports

A.2.15.4.8 Obtain Bureau acceptance and approval of test data

A.2.15.4.9 Obtain Bureau acceptance and approval of Test Plans (Test Management & System Test)

A.2.15.4.10 Obtain Bureau acceptance and approval of Unit Test Plans

A.2.15.4.11 Obtain Bureau acceptance and approval of Integration Test Plans

A.2.15.4.12 Obtain Bureau acceptance and approval of testing of all four (4) integration testing environments

A.2.15.4.13 Complete and Implement Enhanced Testing Environments

A.2.15.4.14 Convert the current Model Office testing environment to a full systems test environment

A.2.15.4.15 Convert the current UAT environment to a regression test environment

A.2.16 Enhancement #7 – Business Process Modeling

A.2.16.1 Summary

The Facilities Manager Contractor must staff a Business Process Modeling section or unit whose main function will be to develop and maintain a complete and detailed business process model of the Bureau of TennCare and Contractor business processes. This will include Bureau direct business processes and indirect business processes, such as DHS eligibility, Program Integrity fraud and abuse investigations, OIR interfaces, and other indirect business processes. The Bureau of TennCare plans to focus on internal processes, but wants the capability to assess the indirect businesses. The Bureau is requesting that the process modeling include Activity Based Costing (ABC). It is difficult to improve the current Bureau of TennCare business processes with the lack of proper documentation.

A.2.16.2 System Functionality Contractor Requirements

A.2.16.2.1 The Contractor must provide their own business process modeling software with viewing and reporting capabilities, as approved by the Bureau.

A.2.16.2.2 The software must be able to create a visual depiction of the business processes documented.

A.2.16.2.3 The Contractor must supply the Bureau with ten (10) licenses of the software the Contractor is using.

A.2.16.2.4 The Contractor must publish the process modeling and activity based costing documentation so that it can be easily viewed and printed by Bureau staff.

A.2.16.3 Business Process Functionality Contractor Requirements

A.2.16.3.1 The Contractor must 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.2.16.3.2 The Contractor must perform business process modeling to identify and document the business process of the Bureau and the Contractor.

A.2.16.3.3 The Contractor must successfully provide a comprehensive, detailed analysis of current Bureau and Contractor business processes.

A.2.16.3.4 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.2.16.3.5 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). Refer to Section A.2.2.1.4.

A.2.16.3.5.1 Define goals of all business processes.

A.2.16.3.5.2 Identify inputs to each business process.

A.2.16.3.5.3 Identify outputs to each business process.

A.2.16.3.5.4 Describe what activities are performed, who performs them, and in what order they are performed, for each step in the business process.

A.2.16.3.5.5 Identify all resources, such as hardware, software and personnel, necessary to complete each business process.

A.2.16.3.5.6 Identify what monitoring takes place.

A.2.16.3.5.7 Outline the Work Plan and language or methodology to be used (within State standards.)

A.2.16.3.6 The Contractor must 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 of TennCare.

A.2.16.3.7 The Contractor must include an assessment of the abilities to enhance the electronic filing and imaging of documents with the current information system.

A.2.16.3.8 The Contractor must determine a migration path for current information systems that allows them to operate in a more user-friendly and efficient environment.

A.2.16.3.9 The Contractor must develop cost/benefit recommendations regarding various projects and initiatives.

A.2.16.3.10 The Contractor must develop an appropriate quality assurance review process.

A.2.16.3.11 The Contractor must 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 must be paid to the use of telephone systems, the use of forms and the use of the web/Internet.

A.2.16.3.12 The Contractor must 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.2.16.3.13 The Contractor must provide a description of the basic concept and proposed methodology for accomplishing the necessary tasks outlined.

A.2.16.3.14 The Contractor must provide the overall project strategy, demonstrating the manner in which all work elements will be combined into the production of the desired results.

A.2.16.3.15 The Contractor must provide a clear vision of what the future business processes will look like, including step-by-step directions, forms to be used, procedures to be followed and the entity that would utilize these steps.

A.2.16.3.16 The Contactor must recommend application solutions that address high volume, labor intensive activities, including solutions that minimize keystrokes and potential errors.

A.2.16.3.17 The Contractor must provide solutions that ensure that all appropriate Bureau of TennCare staff has access to all information, data and processes that are documented during the business process effort.

A.2.16.3.18 The Contractor must 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.2.16.3.19 The Contractor must 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.2.16.3.20 The Contractor must 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.2.16.3.21 The Contractor must maintain and update the business process modeling on an annual basis and integrate with the Change Management Process.

A.2.16.3.22 The Contractor must integrate Activity Based Costing into the process model, which includes:

A.2.16.3.22.1 Analyzing activities

A.2.16.3.22.2 Gathering costs

A.2.16.3.22.3 Tracing costs to activities

A.2.16.3.22.4 Establishing output measures

A.2.16.3.22.5 Analyzing costs

A.2.16.3.22.6 The Contractor must utilize Unified Modeling Language (UML) and use cases for the Business Process Documentation.

A.2.16.4 Contractor Deliverables

A.2.16.4.1 Establish Business Process Modeling Unit.

A.2.16.4.2 Provide overall project strategy and methodology

A.2.16.4.3 Procure Business Process Modeling software

A.2.16.4.4 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.2.16.4.5 Provide assessment of mailroom activities

A.2.16.4.6 Provide assessment of electronic filing and imaging abilities

A.2.16.4.7 Provide assessment of existing information systems

A.2.16.4.8 Provide a comprehensive, detailed Analysis of Bureau of TennCare’s business processes

A.2.16.4.9 Provide a comprehensive, detailed Analysis of Facilities Manager’s business processes

A.2.16.4.10 Obtain Bureau acceptance and approval of Contractor’s assessment of mailroom

activities.

A.2.16.4.11 Obtain Bureau acceptance and approval of Contractor's assessment of the electronic filing and imaging abilities.

A.2.16.4.12 Obtain Bureau acceptance and approval of Contractor's assessment of existing information system.

A.2.16.4.13 Obtain Bureau acceptance and approval of Contractor's comprehensive, detailed Analysis of Bureau of TennCare's business processes.

A.2.16.4.14 Obtain Bureau acceptance and approval of Contractor's comprehensive, detailed Analysis of Contractor's business processes.

A.2.16.4.15 Provide quality assurance review process activities.

A.2.16.4.16 Provide Internet utilization evaluation and recommendations.

A.2.16.4.17 Provide cost-benefit recommendations relating to each Analysis and Assessment.

A.2.16.4.18 Complete and submit for Bureau approval, the Business Process Modeling Enhancement and outline procedures for maintaining Business Process Modeling.

A.2.16.4.19 Provide a thorough Activity Base Costing analysis with each assessment and recommendation.

A.2.16.5 Bureau Responsibilities

A.2.16.5.1 Review Contractor's assessment of Mailroom activities.

A.2.16.5.2 Review Contractor's recommendations for strategy and methodology to accomplish the Business Process Modeling Enhancement.

A.2.16.5.3 Review Contractor's recommendations for electronic filing and imaging.

A.2.16.5.4 Review Contractor's recommendations for existing information system

A.2.16.5.5 Review Contractor's analysis of Bureau of TennCare's business processes.

A.2.16.5.6 Review Contractor's analysis of Contractor's business processes

A.2.16.5.7 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.3 Facility Management Business Process and Functional Requirements

A.3.1 Functional Areas and Business Processes

Listed below are TCMIS functional areas and business processes:

- Integration and Interfaces
- Eligibility and Enrollment
- Correspondence, Letters and Notices
- Complaints/Grievances/Appeals
- Benefit Packages
- 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 must comply with HIPAA standards and transaction code sets rules. The Contractor must maintain the TCMIS interfaces and system design according to HIPAA guidelines, and must 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 paragraph section A.3.2.3)

- Accounting
- Claims and Encounters
- Drug Rebate
- EPSDT
- Eligibility
- Enrollment
- Financial
- Fraud and Abuse (SUR)
- 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) will be implementing their (Vision Integration Platform (VIP) project, which will cause revisions to be needed in the current eligibility interface processes. Details can be found in Attachment 6.10.

A.3.2.1 Interface Listing

A specific list of current 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
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	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

Functional Area	External Entity / Interface	Entity Type	Inbound/ Outbound
EDI/Claims	BHO Capitation Fees - Claim Type 19 - 820	Each BHO	Outbound
EDI	BHO Daily Enrollment/Eligibility File - 834/271U	Each BHO	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
Eligibility	DCS MCO Monthly Extract File	DCS	Outbound

Functional Area	External Entity / Interface	Entity Type	Inbound/ 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 Notice (Term) File	DHS	Outbound
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

Functional Area	External Entity / Interface	Entity Type	Inbound/ 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	Schaller Anderson	Inbound
Eligibility	ProLaw On Request Appeals File	Schaller Anderson	Inbound
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

Functional Area	External Entity / Interface	Entity Type	Inbound/ 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
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	CMS	Outbound

Functional Area	External Entity / Interface	Entity Type	Inbound/ Outbound
	Other Claims File		
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
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

Functional Area	External Entity / Interface	Entity Type	Inbound/ Outbound
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 File	Veteran's Administration	Inbound
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

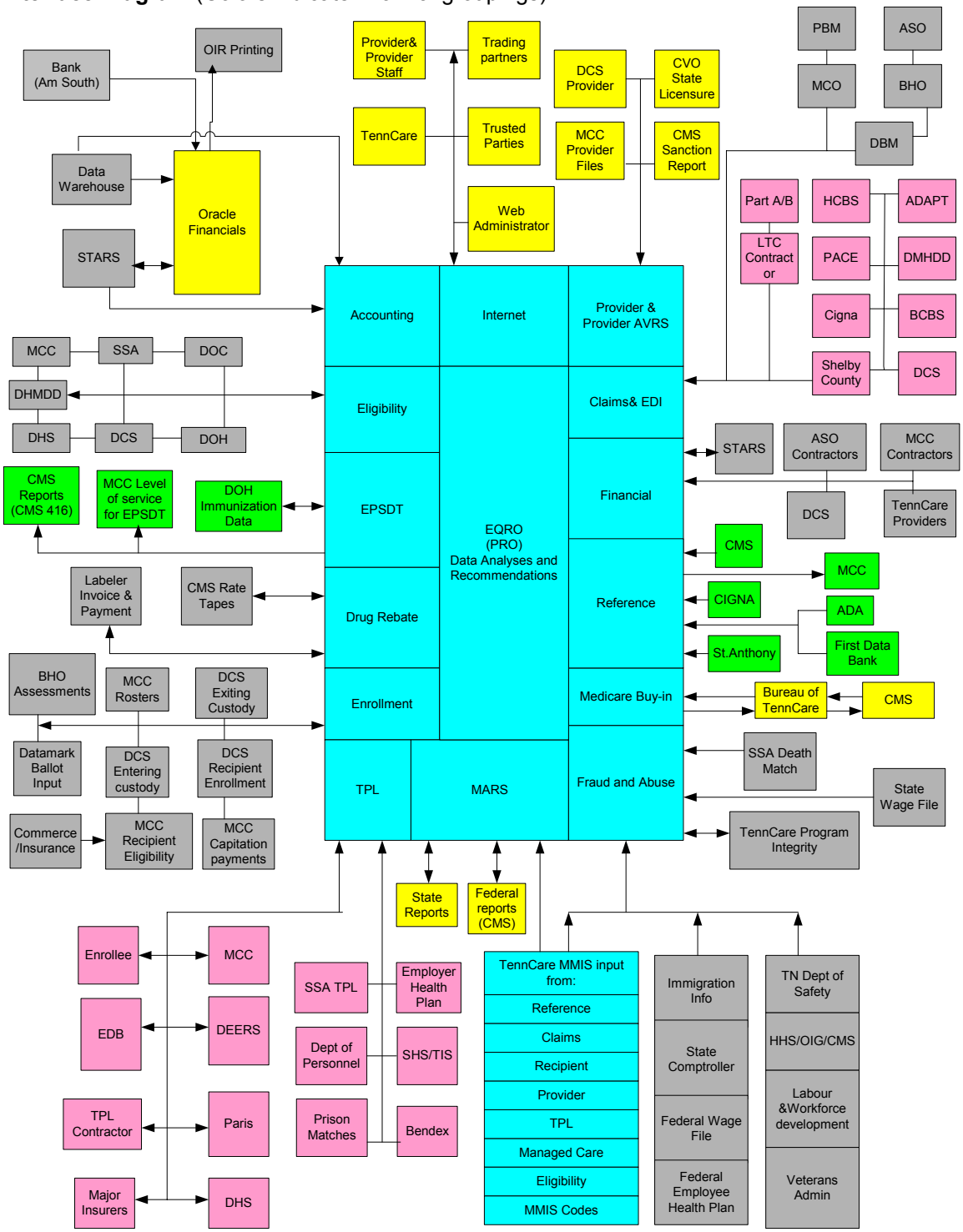
A.3.2.2 New Interfaces

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 will 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 of TennCare exchanges data. The various color groupings are used to indicate data exchanges focused within certain functional areas of TCMIS processing. The Contractor is 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 Managed Care Contractor (MCC) assignments and generates enrollment rosters. The enrollment data is also used for capitation processing and adjustments.

Eligibility determination for both Medicaid and waiver eligibility is performed at the Tennessee Department of Human Services (DHS) under a “single point of intake” policy. Add and update transactions received from DHS are processed in the interChange TCMIS. The Bureau of TennCare also receives eligibility information from the Department of Mental Health and Developmental Disability (MHDD) 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, Title XIX, and other eligibility categories and processing updates from DHS, as well as from other State of Tennessee agencies.

2) Processing enrollment and disenrollment transactions for enrollees in Managed Care Contractor plans in the TennCare Program.

3) Processing recipient plan enrollment change requests.

4) Accepting and managing eligibility records received from DHS and other State of Tennessee agencies during periods of open enrollment.

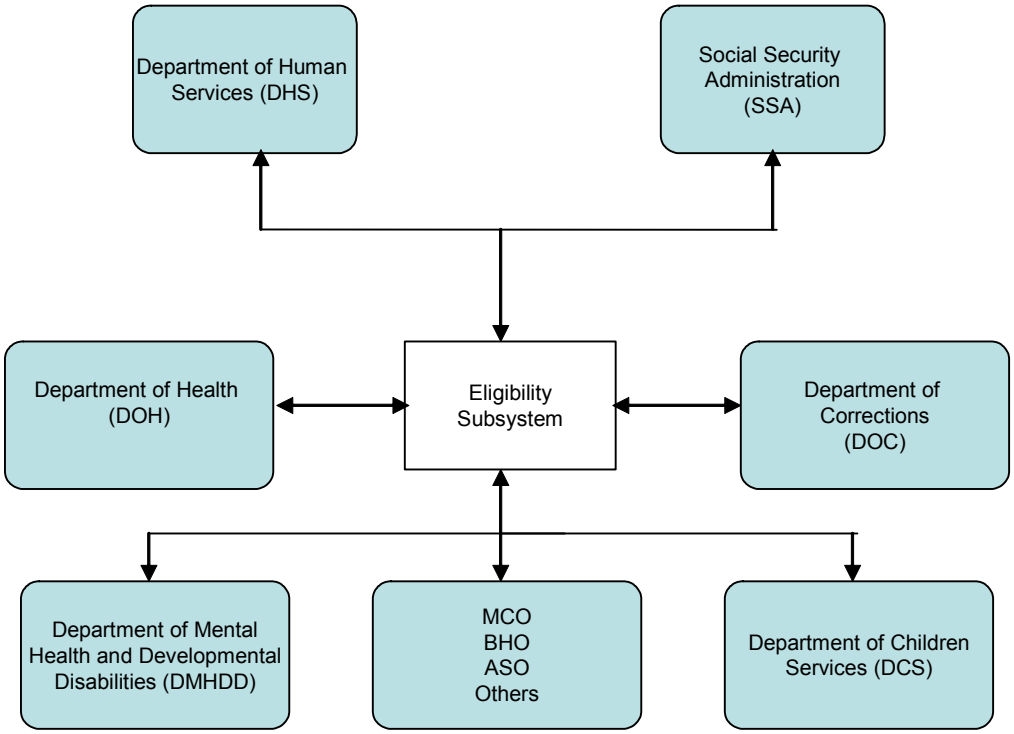
5) Processing eligibility data management and maintenance.

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

This Eligibility Interface Diagram depicts specific interfaces with which eligibility data is exchanged for TCMIS processes. The Contractor is expected to maintain the TCMIS Eligibility processes that utilize the data exchanged to and from these entities.



A.3.3.2 Eligibility and Enrollment Contractor Requirements

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. DOH, DHS, DCS, MR/MHDD, and 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 Managed Care Contractors.

A.3.3.2.11 Generate daily enrollment rosters to Managed Care Contractors 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 Generate enrollee ballots for the annual election of plan enrollment and ensure that only one (1) ballot per household is produced, as needed and defined by the Bureau.

A.3.3.2.14 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.3.3.2.15 Maintain the capability to accept multiple eligibility categories for a unique enrollee identification number simultaneously with effective dates for each eligibility category.

A.3.3.2.16 System logic shall coordinate an enrollee's continued eligibility each time one (1) eligibility effective date segment and/or category terminates, following the Bureau of TennCare business rules, and not terminate coverage until all eligibility periods and/or categories are terminated.

A.3.3.2.17 Support online entry of demographic and eligibility information.

A.3.3.2.18 Maintain edits of inputs of enrollee demographic and eligibility information to ensure consistency and validity of information received through online data entry.

A.3.3.2.19 Maintain an audit trail of changes to demographics and eligibility information.

A.3.3.2.20 Support online viewing of change history.

A.3.3.2.21 Maintain edits of input data as established by the Bureau.

A.3.3.2.22 Report and resolve enrollee records that fail edits during processing.

A.3.3.2.23 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, Managed Care Contractor systems, and other sources of enrollee eligibility and enrollment information.

A.3.3.2.24 Generate and distribute enrollee QMB identification cards as required.

A.3.3.2.25 Generate an audit trail of all QMB cards produced and all online real time updates made.

A.3.3.2.26 Identify the reason for and the date of the issuance of an enrollee eligibility identification card.

A.3.3.2.27 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.3.3.2.28 Maintain process to produce all reports for each eligibility transaction and deliver them as designated by the Bureau of TennCare; notify the Bureau of TennCare of the need to resolve edits if the Contractor cannot resolve them.

A.3.3.2.29 Process and execute daily updates to the Eligibility and Enrollment Data Repository from external eligibility sources in sequential date order.

A.3.3.2.30 Send updates of eligibility and enrollment information in sequential date order to all interfaces as determined by the Bureau of TennCare.

A.3.3.2.31 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.3.3.2.32 Provide online access and processing to the Eligibility and Enrollment Data Repository, twenty-four hours per day, seven days per week (24/7). Additionally, maintenance downtime must be scheduled according to State approved interval time units.

A.3.3.2.33 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.3.3.2.34 Generate and mail standard and ad hoc notices and letters to enrollees on schedule and as requested by the Bureau of TennCare.

A.3.3.2.35 Maintain functionality to provide online file maintenance as directed by the Bureau of TennCare.

A.3.3.2.36 Maintain functionality to support the Bureau's online Automated Voice Response System (AVRS).

A.3.3.2.37 Operate the Eligibility and Enrollment Data Repository and support online real-time and batch eligibility transaction processing twenty-four hours per day, seven days per week (24/7).

A.3.3.2.38 Apply batch updates to the Eligibility and Enrollment Data Repository at least daily on a schedule approved by the Bureau of TennCare and report eligibility transactions which fail edits within four (4) hours. All files must be processed in sequential date order as received.

A.3.3.2.39 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 of TennCare.

A.3.3.2.40 Assist in eligibility file reconciliation processing with MCCs, DHS, SSA or Bureau of TennCare business partner.

A.3.3.2.41 Perform eligibility file maintenance processing, as needed by the Bureau of TennCare.

A.3.3.2.42 Generate capitation payments to MCCs.

A.3.3.2.43 Process capitation payment adjustments.

A.3.3.2.44 Send MCCs capitation information in a HIPAA compliant format.

A.3.3.2.45 Transmit daily electronic enrollment updates to the MCCs in a HIPAA compliant format.

A.3.3.2.46 The Contractor shall complete processing of all MCC address changes within three (3) business days of receipt of address change information. Processes include:

A.3.3.2.46.1 Obtain and file reports that are generated from the 834 file,

A.3.3.2.46.2 Stamp the report with date of receipt and log it into MCO tracking report,

A.3.3.2.46.3 Research the address to determine if the change meets the required criteria for manual update,

A.3.3.2.46.4 Update all addresses that meet the change criteria into interChange,

A.3.3.2.46.5 Perform quality control review on updates to ensure accuracy, and

A.3.3.2.46.6 Forward a copy of all addresses to associated business partners or facilities, if required, to maintain consistency in address data maintenance.

A.3.3.2.47 Operate the recipient eligibility and enrollment component of the TCMIS, including improvements/enhancements as they are implemented.

A.3.3.2.48 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.3.3.2.49 Perform updates or online and/or systematic file fixes to TCMIS-specific fields and tables, as designated by the Bureau.

A.3.3.2.50 Provide assistance to the Bureau in researching enrollee and case file/database discrepancies.

A.3.3.2.51 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.3.3.2.52 Develop and maintain functionality to produce error reports for updates to enrollee and case data that cannot be processed.

A.3.3.2.53 Develop and maintain functionality to provide online access to all TCMIS enrollee files/database tables.

A.3.3.2.54 Maintain the benefit indicator information for enrollees to determine services to which limits apply so that claims can process correctly.

A.3.3.2.55 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.3.3.2.56 Assist Bureau staff with research, resolution, and response to enrollee issues and problems brought to the Bureau's attention.

A.3.3.2.57 Maintain eligibility and enrollee systems documentation for Contractor and Bureau personnel, including, but not limited to, Project Work Book or approved documentation media.

A.3.3.2.58 Generate, deliver to the Bureau of TennCare, and load to online electronic storage repository all enrollee reports according to schedule.

A.3.3.2.59 Generate and transmit a monthly extract file of crossover eligibility including Medicare information to the CMS designated clearinghouse for cross-over claims.

A.3.3.2.60 Purge inactive enrollee records to an archive file, based on the criteria and schedule defined and approved by the Bureau.

A.3.3.2.61 Update system and operations documentation when system changes are made, per standards documented in the TCMIS Infrastructure Documentation Section A.5.8 and A.5.9 of this Contract.

A.3.3.2.62 Maintain eligibility and enrollment data and functionality as required to meet or exceed federal certification requirements.

A.3.3.2.63 Maintain functionality to process temporary SSN terminations, generate notices if required.

A.3.3.2.64 Support process for children turning twenty-one (21). Modify benefit category and generate appropriate notices as required by the Bureau.

A.3.3.2.65 Support process for gaining/losing Medicare. Modify benefit category and generate appropriate notices as required by the Bureau.

A.3.3.2.66 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.3.3.2.67 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.3.3.2.68 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.3.3.2.69 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.3.3.2.70 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.3.3.2.71 Maintain the dunning process, producing notices as required by the Bureau of TennCare. 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.3.3.2.72 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.3.3.2.73 Maintain the Mainframe processes for Medical Eligibility processing.

A.3.3.3 Revised or New Contractor Requirements

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 cannot 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 must 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 for which 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 of TennCare. 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, MSIS, EDB, 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 can undergo an application process to determine if they qualify for Medical Eligibility (ME).

During the ME application process, DHS could approve the enrollee if they have: a qualifying SPMI (severely and persistently mentally ill) assessment within the last year or 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 iC, the enrollee is terminated, and a notice is generated to the applicant. If the enrollee returns the packet and is approved, the Bureau of TennCare 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 cannot be approved as TennCare Standard, not many enrollees who meet the criteria get approved under the ME category.

A.3.3.5 Medical Eligibility Processing Contractor Requirements

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. (Currently, 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 is then to 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 is to 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 is 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- Elig - Medicaid adds & closures.
ACCENT – Reconciliation	DHS; ACCENT	Input	Monthly	EMC; CART	DHS; Elig; 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 coverage for TennCare Standard and Medically Eligible recipients who have been processed via ACCENT.

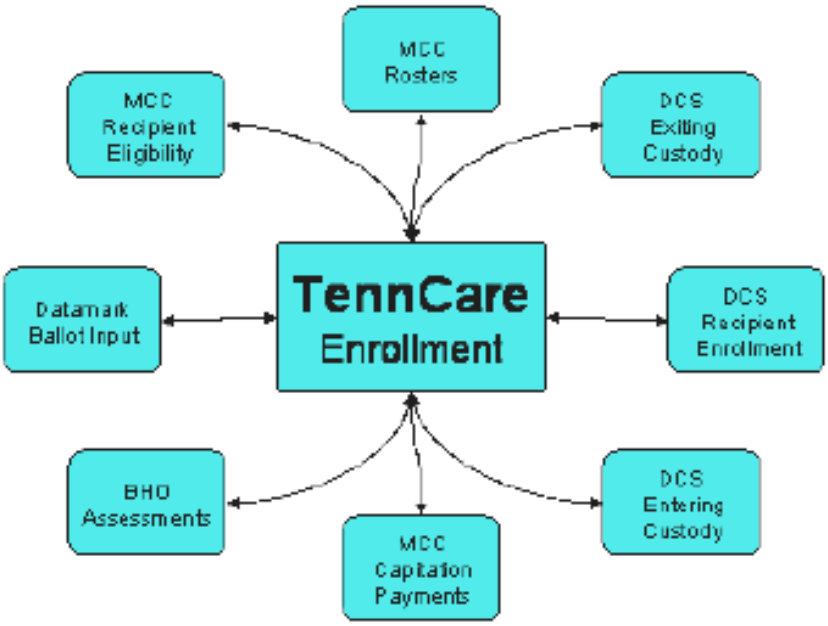
Eligibility Interface	Entity/ Vendor	Input/ Output	Freq	Media	Info/Description
ACCENT Waiver Pend File	DHS	Input	Daily	Data Set	This file has pended applications for the Waiver Recipients.
BENDEX	SSA	Input	Monthly	Cart	Retrieve and update Medicare information daily for effective crossover claim processing, (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- Elig; 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 must 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.
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

Eligibility Interface	Entity/ Vendor	Input/ Output	Freq	Media	Info/Description
					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.
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

Eligibility Interface	Entity/ Vendor	Input/ Output	Freq	Media	Info/Description
					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 today. 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 termed.
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 Set	This file is generated monthly to 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 is 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 is 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.
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.

Enrollment Interface	Entity/ Vendor	Input/ Output	Freq	Media	Info/Description
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	BHO 81 and BHO 82 Good Records and Error Records.
BHO 81 Return File	BHO	Output	Daily	FTP	BHO Assessment Processing Results.
BHO 82 Return File	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 Custody File	DCS	Input	Daily	FTP	Children Exiting Custody will be moved 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.

Enrollment Interface	Entity/ Vendor	Input/ Output	Freq	Media	Info/Description
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 BHO81 File	BHO	Output	Daily	FTP	Contains entering or exiting DCS recipients who are enrolled in BHO81.
DCS Recipients BHO82 File	BHO	Output	Daily	FTP	Contains entering or exiting DCS recipients who are enrolled in BHO82.

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, 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 of TennCare 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, ballots, 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 must 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 must 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 is 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 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 adds, 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 of TennCare 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 of TennCare, 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 Produce and mail, then image, track, process, and verify incoming ballots for MCO selections into the TCMIS, as specified by the Bureau.

A.3.4.2.27 Capture online entered “returned undeliverable mail” information, using changed address information on returned mail to update address files and reprocess outgoing correspondence.

A.3.4.2.28 The Contractor shall process undeliverable correspondence (undeliverables) within ten (10) business days of receipt of the returned undeliverable. This process includes, but is not limited to:

A.3.4.2.28.1 Retrieve undeliverables from post office;

A.3.4.2.28.2 Sort by response type;

A.3.4.2.28.3 Prepare and copy undeliverable envelope front;

A.3.4.2.28.4 Batch and scan copies of the undeliverables;

A.3.4.2.28.5 Index undeliverables;

A.3.4.2.28.6 Forward undeliverables with a forwarding address to the appropriate department for further processing, and maintain tracking report;

A.3.4.2.28.7 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.3.4.2.28.8 Perform quality control on addresses updated in iC to ensure accuracy;

A.3.4.2.28.9 Update tracking inventory and generate weekly status report; and

A.3.4.2.28.10 File and store undeliverables.

A.3.4.2.29 Whenever external printing/mailing services are utilized because of extreme volumes or time constraints, the Contractor must undertake enhanced quality review functions.

A.3.4.2.30 Contractor will 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.3.4.2.31 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.3.4.2.32 Contractor must ensure that correspondence, letters, and notices printed at OIR are promptly reviewed for Q/A, processed, and prepared for mailing, within twenty-four (24) hours of receiving the printed documents.

A.3.4.3 Revised or New Contractor Requirements

The following requirements are functionalities that shall be developed and implemented by the Contractor after Bureau approval.

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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 of TennCare 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 of TennCare 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 of TennCare 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 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 their 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, 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 of TennCare or a Managed Care Contractor, directly to the Bureau of TennCare. 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 of TennCare 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;
- Division of Mental Health and Developmental Disabilities issues; and
- Reimbursement issues.

The Legal Solutions Unit (LSU) within the Bureau of TennCare 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 of TennCare.

The Office of General Counsel (OGC) within the Bureau of TennCare 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
- HCBS and PACE service denial and disenrollment appeals.

A.3.5.3 Complaints/Grievances/Appeals Contractor Requirements

A.3.5.3.1 Image all appeals information and provide online access to related information, including eligibility correspondence.

A.3.5.3.2 Generate an audit trail and track and reconcile all premium payments made as a result of an appeal decision (Note: some non-payments may be "forgiven").

A.3.5.3.3 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.3.5.3.4 Allow access to all claims/encounter claims history that is needed by authorized users regarding appeals processes.

A.3.5.3.5 Generate management reports for administrative appeals to the Appeals

Resolution Tracking System (ARTS) according to schedule as defined by the Bureau.

A.3.5.3.6 Maintain imaging equipment to allow appeal documentation to be scanned into the system at point of receipt, as required by the Bureau of TennCare.

A.3.5.3.7 Develop the methodology to store imaged documents and then allow them to be accessed by Siebel component.

A.3.5.3.8 Maintain the functionality to track appeals twenty-four hours per day, seven days per week (24/7) and allow authorized users to access the appeal or query on the status of an appeal.

A.3.5.3.9 Assign a Bureau defined “type” of complaint, grievance or appeal (e.g. Reimbursement, Medical Necessity, and Pharmacy).

A.3.5.3.10 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.3.5.3.11 Maintain the capability in interChange to produce, distribute, store and reproduce Bureau defined letters and notices associated to a case, which must meet “legal” document standards in the event they are used in hearings.

A.3.5.3.12 For administrative appeals, index imaged documents, (for storing, online viewing, and printing) for an enrollee’s case, and associate the case tracking number to the enrollee, enrollee’s case, matter ID, and appeals tracking number.

A.3.5.3.13 Maintain the functionality to support twenty-four hours per day, seven days per week (24/7) “special needs” Bureau defined identifiers such as hearing impaired, blind or other Bureau defined needs categories.

A.3.5.3.14 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.3.5.3.15 Maintain TCMIS files, systems, and interfaces, which support the administrative legal Complaints, Grievances and Appeals Tracking System.

A.3.5.3.16 Generate and route Complaints, Grievances and Appeals "Alert" report to Bureau defined destinations, by 8:30 a.m. daily.

A.3.5.3.17 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.3.5.3.18 Provide appeal rights on all reprocessed claims denied.

A.3.5.3.19 Update Operational procedures manuals and System documentation where appropriate.

A.3.5.4 Revised or New Contractor 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

Presently, 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 paragraph section detail the services provided for each of the Benefit Plan Indicators. Currently, 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

Benefit Plan B	Coverage
Inpatient Hospital Days	20 days per benefit year
Inpatient Physician Visits (Days)	20 days per benefit year
Physician Visits	12 visits per benefit year
Outpatient Hospital Visits	8 visits per benefit year
Laboratory and Radiology Procedures	10 occasions per benefit year
Dental Services	Not Covered
Methadone Clinic Services	Not Covered
Inpatient and Outpatient Substance Abuse Services	Thirty thousand ($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
Prescription Medication	Not Covered
Inpatient Hospital Days	20 days per benefit year
Inpatient Physician Visits (Days)	20 days per benefit year
Physician Visits	12 visits per benefit year
Outpatient Hospital Visits	8 visits per benefit year
Laboratory and Radiology Procedures	10 occasions per benefit year
Dental Services	Not Covered
Methadone Clinic Services	Not Covered
Inpatient and Outpatient Substance Abuse Services	Thirty thousand dollar ($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	20 days per benefit year
Inpatient Physician Visits (Days)	20 days per benefit year
Physician Visits	12 visits per benefit year
Outpatient Hospital Visits	8 visits per benefit year
Laboratory and Radiology Procedures	10 occasions per benefit year
Dental Services	Not Covered
Methadone Clinic Services	Not Covered
Inpatient and Outpatient Substance Abuse Services	Thirty thousand ($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

Benefit Plan E	Coverage
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
Inpatient Hospital Days	20 days per benefit year
Inpatient Physician Visits (Days)	20 days per benefit year
Physician Visits	12 visits per benefit year
Outpatient Hospital Visits	8 visits per benefit year
Laboratory and Radiology Procedures	10 occasions per benefit year
Dental Services	Not Covered
Methadone Clinic Services	Not Covered
Inpatient and Outpatient Substance Abuse Services	Thirty thousand ($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

Benefit Plan G	Coverage
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	Thirty thousand ($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 ($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
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 of TennCare 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 and a BHO. An exception to this is the two (2) most recently enrolled MCOs for middle Tennessee who provide both medical and behavioral health services. The ASO serves DCS eligible children, Supplemental Security Income (SSI) children, and out-of-state enrollees. 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 a child is 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, 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 of TennCare 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 is 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 of TennCare Policies.

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 (currently 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;

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);

A.3.6.3.23.10 Percentage of RBRVS;

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 of TennCare.

A.3.6.3.27 Process and maintain rate updates generated from internal Bureau of TennCare 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 updates and changes.

A.3.6.4.3 Notify the Contractor of rate and fee schedule updates and changes.

A.3.7 EPSDT

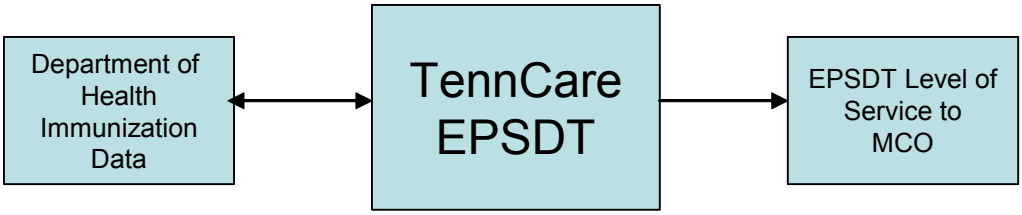
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federally mandated program issued to provide health care services to children from birth to age twenty (20). The TennCare program extends the EPSDT benefit to also include the uninsured/uninsurable under age twenty-one (21) population. 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.

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 EPSDT Contractor Requirements

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, appointments, 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 of TennCare.

A.3.7.2 EPSDT Inputs and Outputs

This table lists information about specific files that are used in EPSDT processing: The Contractor is 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.

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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 of TennCare 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, Part D, 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, Part D, 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 is 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
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 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. They 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, HIPP, and enrollee refunds and reimbursements.

The Contractor maintains 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; which 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 poverty must 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 will 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 of TennCare 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, county or geographic area, 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 variable premium payment plans to accommodate enrollee payment of past due amounts and update termination effective date if payment is not received.

A.3.9.4.7 Maintain functionality to select, validate, and apply the correct premium rate to

each monthly premium statement.

A.3.9.4.8 Maintain the functionality to suspend billing member premiums through an online update, (e.g. for periods of time covered by bankruptcy or appeals).

A.3.9.4.9 Maintain capitation (both administrative fee and at-risk payments to MCCs) information.

A.3.9.4.10 Maintain the capitation rate payment history, including initial payments, retroactive adjustments, and associated rate files.

A.3.9.4.11 Maintain data available for calculation of capitation to MCCs.

A.3.9.4.12 Maintain capitation rate change history with effective date processing.

A.3.9.4.13 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.3.9.4.14 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.3.9.4.15 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.3.9.4.16 Maintain functionality to track and report capitation payments with payment dates on file.

A.3.9.4.17 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.3.9.4.18 Maintain functionality to calculate capitation rates for each benefits schedule within a single Managed Care Contractor.

A.3.9.4.19 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.3.9.4.20 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 must be incorporated into the payment and disbursement adjustment process and remittance advice.

A.3.9.4.21 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.3.9.4.22 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.3.9.4.23 Maintain process to post adjustments (write-offs) and identify the reason and source for the adjustment.

A.3.9.4.24 Maintain the process to identify and track providers who are in the process of bankruptcy and identify the type of bankruptcy (Chapter 7, 11, or 13).

A.3.9.4.25 Maintain process to suspend billing for provider recoupments in process and cease making payments to providers.

A.3.9.4.26 Maintain process to generate second invoices, retain copies, and provide online viewing of the drug rebate invoices.

A.3.9.4.27 Maintain process to generate second invoices, retain copies, and provide online viewing of all financial invoices.

A.3.9.4.28 Maintain process to generate an audit log for the purpose of tracking expenditures.

A.3.9.4.29 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.3.9.4.30 Balance and reconcile output payments.

A.3.9.4.31 Maintain process to generate a FCR and identify the financial action to be taken.

A.3.9.4.32 Maintain financial audit and control capabilities.

A.3.9.4.33 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.3.9.4.34 Maintain process to track and report all record change events and maintain an audit trail, and provide online access by approved users.

A.3.9.4.35 Maintain the ability to display an unlimited number of event occurrence changes in date order.

A.3.9.4.36 Support process to post partial payments and overpayments to the appropriate records.

A.3.9.4.37 Provide system support for basic financial and accounting functions and reporting capabilities.

A.3.9.4.38 Maintain functionality to recognize retroactive and current changes made to the eligibility file that would affect capitation adjustments.

A.3.9.4.39 Maintain functionality to generate quality control management reports to support capitation cycle integrity and error detection with balancing features.

A.3.9.4.40 Support functionality to record liquidated damages for MCCs, carry the reason code on the record and calculate and post adjustments immediately.

A.3.9.4.41 Maintain functionality to generate provider and enrollee payments through ACH funds transfers sent through the STARS system.

A.3.9.4.42 Maintain process to generate disbursement transactions through STARS (or State's Accounting system), to support electronic funds transfer (EFT) or Journal Vouchers to Bureau of TennCare business partners such as banks, contractors, government agencies, and providers, according to the guidelines established by the Tennessee Department of Finance and Administration.

A.3.9.4.43 Identify the voluntary election of EFT by the payee and schedule EFT transfer.

A.3.9.4.44 Ensure that the CMS-21 report is generated according to the Bureau's schedule.

A.3.9.4.45 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.3.9.4.46 Ensure that the MSIS (CMS-2082) report is produced according to the Bureau’s schedule.

A.3.9.4.47 Operate the Bureau of TennCare's Financial Management functions effectively, efficiently, and in compliance with the performance standards and applicable State and federal policy, law, and regulation.

A.3.9.4.48 Provide and maintain staff knowledgeable in policy and procedures as they pertain to the financial management requirements of the Bureau of TennCare program.

A.3.9.4.49 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.3.9.4.50 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.3.9.4.51 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 of TennCare.

A.3.9.4.52 Produce remittance statements (hard copy and electronic) and mail, transmit, or dispatch to the correct providers and business partners.

A.3.9.4.53 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.3.9.4.54 Generate a payment register to the Bureau of TennCare and the STARS (or Edison when implemented) system at the end of each claims payment cycle, as specified by the Bureau of TennCare.

A.3.9.4.55 Update claims history and financial files with the check number, date of payment, and amount paid after the claims payment cycle.

A.3.9.4.56 Perform adjustments to original and adjusted claims and maintain records of the

previous processing.

A.3.9.4.57 Provide for the proper handling of returned checks, including the appropriate fee for insufficient funds.

A.3.9.4.58 Provide 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.3.9.4.59 Develop and maintain process to report principal and interest amounts owed by providers, drug labeler, or other organizations on accounts receivable.

A.3.9.4.60 Provide twenty-four hours per day, seven days per week (24/7) online access to financial information, including claims, capitation, premium, and provider payment information.

A.3.9.4.61 Prepare and submit a report to the Bureau of TennCare separately listing all inappropriate and/or incorrect payments.

A.3.9.4.62 Update and maintain financial transaction balances of paid and collected amounts for each provider, MCC, and all other entities.

A.3.9.4.63 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.3.9.4.64 Produce and mail enrollee premium statements and notices to enrollees.

A.3.9.4.65 Bill for premiums due from uninsured and uninsurable enrollees.

A.3.9.4.66 Collect and post premium payments and adjustments. The current Facilities Manager contracts with a bank to do the collections via a "lock box" and provides a tape of the payment transactions.

A.3.9.4.67 Provide for distributing of special fund pools as directed by the Bureau of TennCare. Additionally, review the special funds pool calculation and distribution process and propose improvements to the Bureau of TennCare.

A.3.9.4.68 Operate the Accounting/Financial functions to ensure that all Bureau of TennCare funds are appropriately disbursed for claims payments and that all post-payment transactions are applied accurately.

A.3.9.4.69 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 of TennCare.

A.3.9.4.70 Maintain an automated interface with STARS (or Edison when implemented), to support direct data transfers.

A.3.9.4.71 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.3.9.4.72 Maintain functionality to process and generate managed care payments for managed care providers.

A.3.9.4.73 Update the claims history file/database with the warrant numbers, date of payment, and amount paid information.

A.3.9.4.74 Perform all internal balancing activities to ensure accurate disbursement of payments, as defined by the Bureau.

A.3.9.4.75 Provide online access to claims.

A.3.9.4.76 Provide functionality to update financial information.

A.3.9.4.77 Update system and operations documentation when system changes are made.

A.3.9.4.78 Develop and maintain functionality to process files received from collection agency and reverse claims that have been recouped.

A.3.9.5 Revised or New Contractor 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, February 28, 2009, the Contractor will 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 will 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 is responsible to produce monthly reports to account for categories of expenditure to the federal government. The Contractor is 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 don't 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 of TennCare.

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 of TennCare and providers.

A.3.9.5.7 Maintain functionality to systematically generate a dunning summary to request payment of outstanding A/R, 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 will 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 is 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

Accounting/Financial Interface	Entity/ Vendor	Input/ Output	Freq	Destination/Info/Description
				once a day and will process any invoices that are in the correct state that have not already been interfaced to STARS. 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 is 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 (via 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 of TennCare invoices drug manufacturers quarterly for the units of drugs that are dispensed in each quarter.

The Bureau of TennCare 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, and develop and maintain a process to allow manufacturers to access the rebate files and invoices via 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 track and transmit drug rebate receivables to STARS (or Edison when implemented).

A.3.10.1.6 Maintain process to adjust rebate rates and post previous period voids and adjustments.

A.3.10.1.7 Monitor the status of each accounts receivable; including enrollee, provider, contractor, and Drug Rebate. Report monthly, quarterly, and on request to the Bureau of TennCare in aggregate and/or individual accounts, both on paper and online as directed by the Bureau of TennCare.

A.3.10.1.8 Operate the Drug Rebate Subsystem of the TCMIS, including improvements/enhancements as they are implemented.

A.3.10.1.9 Maintain a drug manufacturer data set for processing drug rebate invoices (currently received from CMS).

A.3.10.1.10 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.3.10.1.11 Develop, store online, and maintain the capability to process supplemental drug rebate invoices.

A.3.10.1.12 Develop, enhance, and maintain outlier reports on current and historical claims, on a schedule and as defined by the Bureau.

A.3.10.1.13 Develop and maintain the capability to correct and recreate drug rebate invoice.

A.3.10.1.14 Maintain and produce all drug rebate reports, on a schedule and as defined by the Bureau.

A.3.10.2 Revised or New Contractor 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 is expected to maintain during the Drug Rebate processing. Refer to Attachment 6.1.4 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
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, Encounter History and Financial Transactions 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 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 (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 of TennCare directly.
- MHDD: Psychiatric Institutions within the Department of Mental Health and Developmental Disability (MHDD) submit claims for inpatient services directly to the Bureau of TennCare.

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 must 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.

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. (This function is currently provided by TennCare's PBM.)

A.3.11.1.2 Adjustments

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 to change a claim.

Providers initiate adjustments electronically or through correspondence, which is then entered through the adjustment windows. Electronic adjustments are sent in via the HIPAA standard transaction sets through the Electronic Data Interface (EDI) to the Claims subsystem. Provider correspondence comes through 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 will occur when provider per diems are altered. Claims are automatically selected and processed using the adjustment windows. Adjustment clerks can then view the net effect and decide how to complete the mass adjustments. Other criteria can be used to select claims in an ad-hoc approach. Using the same mass adjustment windows, operators can review and process the adjustments with the same controls. With the mass adjustment function, corrections can 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. Skilled Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded), in Home and Community Based Services (HCBS) waiver programs for the mentally retarded or the elderly and disabled, and in the Program of All-inclusive Care for the Elderly (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 can 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 must 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) Preadmission Evaluations (PAE) per year for individuals seeking Medicaid reimbursement of nursing home care, ICF/MR services, HCBS waiver programs, and PACE (Program of All-inclusive Care for the Elderly) 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 Skilled Nursing Facilities 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 PASARR finding, which indicates the need for specialized services.

A.3.11.1.4.4 PAE Appeal Process - About 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 Orders. The Bureau of TennCare 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 of TennCare must pay for services even if the service(s) is 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. Currently 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 of TennCare 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 point two (1.2) million enrollees, including six hundred forty thousand (640,000) children. Payment transactions are generated to eight (8) MCOs and two (2) BHO Contractors.

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 (820s) are generated and distributed via electronic file transfer to the Managed Care Contractors. The posting of payments is interfaced to STARS.

Whenever capitation adjustments are needed, either manual adjustments can 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. There are currently 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 can be found in MCC Contracts.

A.3.11.2.2 BHO Capitation Payment Process

Behavioral Health Organization (BHO) capitation payments are based on a negotiated annual fixed amount. Payments are paid monthly to each of the two (2) 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 Program of All-Inclusive Care for the Elderly (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 must deliver information concerning errors or exceptions directly to the Bureau within a timeframe defined by the Bureau.

A.3.11.3.7 The Contractor must maintain the Edifecs SpecBuilder, XEngine and Transaction Manager software.

A.3.11.3.8 The Contractor must 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 must 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 of TennCare business processes.

A.3.11.3.10 The Contractor must 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 of TennCare.

A.3.11.3.11 The Contractor must 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 must utilize Transaction Manager to automate error management and exception handling.

A.3.11.3.13 The Contractor must deliver information concerning errors or exceptions directly to the Bureau within a timeframe defined by the Bureau.

A.3.11.3.14 The Contractor must 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, per Bureau of TennCare standards.

A.3.11.3.16 Process FFS claims at least weekly, on a schedule established by the Bureau of TennCare, 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 RA and billing records for SNFs.

A.3.11.3.19 Reimburse FFS providers via 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 of TennCare 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, per Bureau of TennCare 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 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 Support pseudo pricing of encounters to support analysis of what would have been paid under a fee for service environment.

A.3.11.3.31 Maintain processing of electronic TAD-like claims.

A.3.11.3.32 Support electronic claims capture and processing for all claim types.

A.3.11.3.33 Maintain logic and consistency editing to screen the claim before accepting the claims or encounter data into the TCMIS.

A.3.11.3.34 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.3.11.3.35 Maintain the process to accept, control, process, and report claims separately for Medicaid and State-only and other programs as defined by the Bureau of TennCare.

A.3.11.3.36 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.3.11.3.37 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.3.11.3.38 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.3.11.3.39 Maintain process to accept claims via 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.3.11.3.40 Maintain production of control and audit trail reports during various stages of the claims processing cycle.

A.3.11.3.41 Maintain process to edit each data element of the claim or encounter record for required presence, format, consistency, reasonableness, and/or allowable values.

A.3.11.3.42 Maintain process to perform automated edit processing using history claims, pended claims, in-process claims, and same-cycle claims.

A.3.11.3.43 Maintain process to provide, for each error code, a 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.3.11.3.44 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 of TennCare specified data for the date of service on the claim.

A.3.11.3.45 Maintain functionality to automatically deduct enrollee deductible amounts, patient liability, enrollee co-payments, and TPL amounts, as appropriate, when pricing claims.

A.3.11.3.46 Maintain process to perform global changes to pended claims based on Bureau of TennCare-defined criteria.

A.3.11.3.47 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.3.11.3.48 Maintain functionality to provide a purge function to purge inactive records to an archive file based on criteria established by the Bureau of TennCare.

A.3.11.3.49 Maintain indefinitely on a permanent history archive with key elements of the history claim, the claims that have been purged from active history.

A.3.11.3.50 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 of TennCare-approved procedures.

A.3.11.3.51 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.3.11.3.52 Maintain edits for each claim record during an edit cycle, and report each edit failure reason on provider remittance statements.

A.3.11.3.53 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.3.11.3.54 Identify, track, and monitor all edits posted to the claim.

A.3.11.3.55 Identify and hierarchically assign status and disposition of claims and encounter claims that fail edits.

A.3.11.3.56 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.3.11.3.57 Maintain edits for potential and exact duplicate claims, including cross-references between groups and rendering providers, multiple provider locations and across provider and claim types, categories of service, and Bureau-defined financial fund codes and chart of accounts.

A.3.11.3.58 Maintain process to identify and calculate payment amounts according to the fee schedules, per diems, DRG rates, and other rates and rules established by the Bureau.

A.3.11.3.59 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.3.11.3.60 Maintain the capability to pend claims for providers based on Bureau of TennCare-defined parameters.

A.3.11.3.61 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.3.11.3.62 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.3.11.3.63 Process all claims, including those from out-of-state providers.

A.3.11.3.64 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 of TennCare, in the most effective and efficient means available.

A.3.11.3.65 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.3.11.3.66 Archive hard-copy claims, and accompanying documentation.

A.3.11.3.67 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.3.11.3.68 Maintain the process to perform validity editing on entered claims and encounters against Provider, Recipient, Financial, Claims History, TPL, and Reference data files.

A.3.11.3.69 Generate and submit claims entry statistics reports.

A.3.11.3.70 Provide appropriate staff to support both technical and informational aspects of EDI. Staff must 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.3.11.3.71 Maintain capability to supply EDI application and PC interface software to providers, including installation and troubleshooting assistance to providers.

A.3.11.3.72 Maintain system functionality to perform editing for submitted claim data.

A.3.11.3.73 Ensure that claims adjudication is in accordance with medical policies in effect at the time of provision of service.

A.3.11.3.74 Maintain functionality to price claims in accordance with TennCare policies and/or rules, benefits, and limitations as defined by the Bureau of TennCare.

A.3.11.3.75 Process Medicare coinsurance and deductible charges received on hard copy and electronic media.

A.3.11.3.76 Maintain the method to process for payment any specific claim(s), including claims from MCCs to be paid under stop-loss provisions, as directed by the Bureau of TennCare, on an exception basis; and maintain an online audit trail.

A.3.11.3.77 Manually and systematically review and resolve any claims that pend for any of the edits as determined by the Bureau of TennCare.

A.3.11.3.78 Maintain standard claims control and tracking standards.

A.3.11.3.79 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 of TennCare defined guidelines.

A.3.11.3.80 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.3.11.3.81 Provide ongoing training to the Bureau of TennCare and Contractor staff in the use of the claims processing system and as requested.

A.3.11.3.82 Generate claims entry statistics, EDI claims submission, inventory, and operations reports, and make available to the Bureau of TennCare in the required format.

A.3.11.3.83 Calculate and report to the Bureau of TennCare, 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.3.11.3.84 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.3.11.3.85 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 should also apply to all claims, TAD 837I interface, and encounter data accepted online real time. Reports shall be provided online and be available using the dashboard report tool within one (1) business day.

A.3.11.3.86 Generate, review for accuracy, and submit claims inventory and statistical reports after each claims processing cycle.

A.3.11.3.87 Update the claims and encounter entry files daily (as received).

A.3.11.3.88 Retrieve hard-copy claim documentation/correspondence images as requested by Bureau staff, and within the required time frame.

A.3.11.3.89 Perform claims processing activities which include, but are not limited to, mail sort, batching, imaging, data entry, pend resolution, and adjudication.

A.3.11.3.90 Receive and correctly process all claims adjustment requests.

A.3.11.3.91 Process all claims-related electronic transactions.

A.3.11.3.92 Provide hardcopy and/or imaged copies for all requests for claims, attachments, correspondence and applications.

A.3.11.3.93 Receive and process encounters from MCCs; analyze data quality and provide the Bureau of TennCare with an assessment and recommendations for corrective action, if appropriate.

A.3.11.3.94 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.3.11.3.95 Provide regular reporting of status to Bureau Business Users.

A.3.11.3.96 Process all claims and work with the Bureau of TennCare to resolve any identified problems.

A.3.11.3.97 Provide claim extracts from online and archived history as necessary to meet the Bureau of TennCare's needs.

A.3.11.3.98 Submit a monthly report listing separately all Contractor or Bureau identified inappropriate and/or incorrect provider payment.

A.3.11.3.99 Monitor claims throughout production, including, but not limited to, claims backlogs, data entry backlog, suspense file status, and other performance measures.

A.3.11.3.100 Monitor claims and inventory balances to determine where backlogs are occurring and report findings to the Bureau.

A.3.11.3.101 Monitor and track claims volume for potential impacts on the contracted fixed price cost estimate.

A.3.11.3.102 Monitor claims processing and provider payments to ensure accuracy of payments and integrity of files.

A.3.11.3.103 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.3.11.3.104 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 should include a cross-reference that allows easy retrieval of the returned claim.

A.3.11.3.105 Maintain a daily log of claims returned to providers including documented issue(s) with the claim.

A.3.11.3.106 Provide the Bureau staff full and complete access to the log of claims and the copies of claims returned to providers.

A.3.11.3.107 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.3.11.3.108 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.3.11.3.109 Perform a daily quality control sample of the documents imaged that day.

A.3.11.3.110 Conduct a sample audit of all claim types weekly to assure the TCMIS is processing claims correctly.

A.3.11.3.111 Establish balancing procedures and reports to ensure control within the TCMIS processing cycles and reconcile any differences.

A.3.11.3.112 Maintain adequately staffed data entry and resolution units to process claims

within the time frames specified by this Contract.

A.3.11.3.113 Perform data entry of all hard-copy claims and claim-related documents with Bureau of TennCare approved quality assurance controls.

A.3.11.3.114 Identify and report all claims replacements (e.g. adjustments and reconsiderations) resulting from Contractor processing errors.

A.3.11.3.115 Perform Bureau approved validity editing on all entered claims against provider, enrollee, reference, and other TCMIS data.

A.3.11.3.116 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.3.11.3.117 Maintain a claims inventory and control system as approved by the Bureau.

A.3.11.3.118 Maintain a permanent record of all claims/encounter claims received. The record should 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.3.11.3.119 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.3.11.3.120 Produce online and hard-copy balancing and control reports, according to Bureau specifications.

A.3.11.3.121 Make written recommendations on any area in which the Contractor or Bureau thinks improvement can be made.

A.3.11.3.122 Operate the Claims/Encounter Processing component of the TCMIS, including improvements/enhancements as they are implemented.

A.3.11.3.123 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.3.11.3.124 Execute claims/encounters processing cycles and generate outputs on a Bureau-approved schedule, in accordance with the standards approved by the Bureau.

A.3.11.3.125 Process Bureau-approved formats and claim forms.

A.3.11.3.126 Generate and process managed care payments and reconciliation for Managed Care Contractors (MCCs).

A.3.11.3.127 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.3.11.3.128 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.3.11.3.129 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.3.11.3.130 Maintain functionality to edit all claims in accordance with TennCare policies and/or rules, benefits, and limitations as defined by the Bureau.

A.3.11.3.131 Price all claims in accordance with TennCare policies and/or rules, benefits, and limitations as defined by the Bureau.

A.3.11.3.132 Provide the Bureau with online inquiry access to current claims status data, based on appropriate security.

A.3.11.3.133 Maintain functionality to provide online access to the claims history file/database.

A.3.11.3.134 Provide online access to suspended claims data and the exception control file defining the disposition of edits and audits.

A.3.11.3.135 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 should be based on the final disposition date of the claim.

A.3.11.3.136 Provide online access to the thirty-six (36) months of claims history.

A.3.11.3.137 Maintain six (6) years of history for nursing facility paid claims, as prescribed by the Bureau, for processing retroactive rate adjustments. Contractor must retain the history archive for the life of the Contract, as specified by the Bureau, so that historical claims records can be extracted on an exception basis for audits or other purposes.

A.3.11.3.138 Maintain all claims data elements defined by the Bureau on claims history.

A.3.11.3.139 Maintain an adequately staffed claims resolution unit to resolve claims suspended for edits and audits designated by the Bureau.

A.3.11.3.140 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.3.11.3.141 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.3.11.3.142 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.3.11.3.143 Ensure that suspended claims are resolved in accordance with Bureau-approved procedures.

A.3.11.3.144 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.3.11.3.145 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 must be stored as long as the associated claim is stored in the online and history database.

A.3.11.3.146 Maintain procedures to identify claims suspended as a result of data entry errors and correct such errors.

A.3.11.3.147 Obtain Bureau approval for all new remittance statements and/or codes developed by the Contractor.

A.3.11.3.148 Maintain and update claims control, exception control, medical criteria, benefit limits, and other parameter files as required and in accordance with Bureau of TennCare approved change control procedures.

A.3.11.3.149 Prepare, validate, and distribute operational and performance reports.

A.3.11.3.150 Produce and submit to the Bureau, all required claims and encounter processing reports.

A.3.11.3.151 Maintain functionality to support ability to mass adjust paid and denied claims, as requested.

A.3.11.3.152 Update system and operations documentation when system changes are made.

A.3.11.3.153 Develop a plan of action to correct and track to completion errors discovered during the claims and encounter reviews.

A.3.11.3.154 Process all claims and encounters that are required to be reprocessed in the same sequence they were originally processed.

A.3.11.3.155 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; system identifies all error codes for claims that fail processing edits at initial processing to minimize the need for multiple re-submissions of claims.

A.3.11.3.156 Provide capability to accept global changes to suspend claims based on Bureau-defined criteria and to release claims to editing.

A.3.11.3.157 Provide for capture and editing of the rendering provider number for all claims.

A.3.11.3.158 Provide editing of all claims, including fee-for-service, encounter, and cross-over, in accordance with Bureau approved edit/audit criteria; 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.3.11.3.159 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.3.11.3.160 Identify and implement Policies and Procedures as they relate to the contractually agreed upon tasks.

A.3.11.3.161 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.3.11.3.162 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.3.11.3.163 Collaborate with the Bureau in establishing and maintaining the State Medicaid payment rates and methodology, for Bureau approval.

A.3.11.3.164 Process and generate provider and enrollee claims history requests.

A.3.11.3.165 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.3.11.3.166 Image claims and any attachments; process/archive every claim and attachment within one (1) business day of receipt.

A.3.11.3.167 Assign a unique claim reference to electronic media captured claims, voids, and adjustments within one (1) business day of the date received.

A.3.11.3.168 Return within one (1) business day of receipt, claims that have missing or unreadable required data. Any attachments must be returned with the claims. Instructions for the providers on how to correct and resubmit the returned claims must be included when the claims are returned to the provider and tracked via an audit trail. All claims correspondence sent to and retrieved from providers must be imaged and associated with the provider's record. All correspondence must be stored and retrievable online upon authorized user demand.

A.3.11.3.169 Update claims data resubmitted by providers within three (3) business days of receipt.

A.3.11.3.170 Balancing and control reports shall be viewable online and available for authorized users to account for all claims at all times. All reports should also be made available via the web portal if requested by authorized users.

A.3.11.3.171 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 will be used to support

the certification process.

A.3.11.3.172 Ensure that payments are made within thirty (30) days after receipt by the system of an error free claim.

A.3.11.3.173 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.3.11.3.174 Execute production of an explanation of benefits (EOBs) at a frequency defined by the Bureau of TennCare, (e.g. weekly, daily).

A.3.11.3.175 Generate an EOB at least monthly to every recipient on whose behalf claims have been paid since the last EOB.

A.3.11.3.176 Support the process to send out EOBs within forty-five (45) days of the payment of claims to recipients who receive services from FFS providers

A.3.11.3.177 Ensure that a prompt written notice Recipient Explanation of Medical Benefits (REOMB) is provided to recipients who are furnished services covered by the State plan and contains the name of the recipient, address of recipient, a recipient identification number, date(s) of services, specific service(s), cost(s) of service(s), and name(s) of provider(s).

A.3.11.3.178 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.3.11.3.179 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.3.11.3.180 Support preparation of payment instruments and their supporting documents.

A.3.11.3.181 Support the field for authorization or identification when an override indicator (force code) is used, as required for certification.

A.3.11.3.182 Develop and maintain the functionality to track and report all provider requests for claims reconsideration. Provide weekly/monthly reporting on all requests.

A.3.11.3.183 Maintain functionality to re-process claims, and provide assistance in claims resolution where research is needed for corrective action.

A.3.11.3.184 Contractor must evaluate denied claims for reason of "out of timely filing" to determine if there are any extenuating circumstances.

A.3.11.3.185 Evaluate the use of claims system assigned keys (SAKs) and recommend alternative processes to avert systems limitations.

A.3.11.3.186 Ensure that all edits and audits are HIPAA compliant.

A.3.11.3.187 Maintain a fully functional claims resolution staff (who are accountable) to resolve aged suspended and pended claims.

A.3.11.3.188 Develop and maintain test environments needed to emulate production data and code so that the Bureau can test all system edits.

A.3.11.3.189 Develop and produce a report that extracts the data from X12 and is provided in a Bureau of TennCare designed format when requested by the Bureau. Produce within one (1) business day.

A.3.11.3.190 Generate paper copy of sample RAs for each financial cycle, based on a list of providers supplied by the Bureau.

A.3.11.3.191 Maintain a comprehensive Claims Adjudication Manual for approval by the Bureau.

A.3.11.3.192 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.3.11.3.193 Develop and perform staff training to include plans for cross-training resolution staff in all edits and audits.

A.3.11.3.194 Establish and maintain facility and infrastructure requirements to accommodate a centralized organization for resolution of claims.

A.3.11.3.195 Develop, review, and produce reporting of claims processing metrics for monthly status reporting to the Bureau.

A.3.11.3.196 Develop and maintain functionality to process web interface adjustments.

A.3.11.3.197 Maintain functionality to produce and mail Daniels letters.

A.3.11.3.198 Maintain the capability to receive, process, store, and forward HIPAA compliant files and provide HIPAA compliant Remittance Advices.

A.3.11.3.199 Develop and Produce management reports that allow Bureau staff to monitor data from the input source to back-end reporting databases.

A.3.11.3.200 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.

A.3.11.3.201 Contractor guarantees referential integrity within the table structure and not within the coding structure.

A.3.11.3.202 Monitor, review, and update as needed, and work all edits and audits for a claim.

A.3.11.3.203 Assign a unique claim reference number to every paper claim, void, and adjustment within one (1) business day of the date received. Attachments should receive the same unique number as the document to which it is attached.

A.3.11.3.204 Maintain data entry keying accuracy standards of ninety-nine percent (99%) for claims and other transactions.

A.3.11.3.205 Maintain capability to accept online real time submission of TAD-like claims and encounter data, via portal entry twenty-four hours per day/seven days per week (24/7). Online claims, fee-for-service and encounter data must have a unique claim reference number assigned, including time received, upon entry into the TCMIS system.

A.3.11.3.206 Process, edit, and adjudicate claims and encounters five (5) times per week or as directed by the Bureau of TennCare.

A.3.11.3.207 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 via EDI shall be processed in twenty-one (21) calendar days. One hundred percent (100%) of clean claims that are received via paper shall be processed in thirty (30) calendar days.

A.3.11.3.208 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 Revised or New Contractor 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 them 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.3.11.5 Claims/Encounter Claims Inputs and Outputs

The following table lists information about specific files that the Contractor is 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/Encounter Interface	Entity/ Vendor	Input/ Output	Freq	Media	Destination/Info/Description
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 of TennCare Third Party Liability Unit is responsible for identifying and recovering payments that were made inappropriately. The Bureau of TennCare contracts with Health Management System (HMS) to recoup money paid to providers for recipient's claims that subsequently were found to have TPL. Since the Bureau of TennCare 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 of TennCare'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 of Tennessee 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 of TennCare because of Post Pay Billings. Letter details can 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 TPL Contractor Requirements

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; and 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 should 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 of TennCare.

A.3.12.2.19 Provide training to the Bureau of TennCare 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 of TennCare 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 of TennCare.

A.3.12.2.24 The Contractor will 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 will 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 all carriers in Tennessee;

A.3.12.2.24.4 Assign staff to post recoveries from the TPL contractor and all other sources 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 application,

A.3.12.2.25 Contractor personnel will 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 is thirty (30) per day.

A.3.12.2.26 Generate and mail questionnaires regarding suspect TPL resource information.

A.3.12.2.27 Contractor personnel will receive the updated questionnaires, scan the forms and index them for future reference. The data on the questionnaires will be manually uploaded into the system by the Contractor.

A.3.12.2.28 Maintain the TPL component of the TCMIS, including improvements/enhancements as they are implemented.

A.3.12.2.29 Provide the Bureau with online access and update all TPL components and system files, as needed by the Bureau.

A.3.12.2.30 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.3.12.2.31 Develop and provide automated interfacing capabilities with external entities pertaining to the processing of third-party liability information.

A.3.12.2.32 Maintain functionality to capture and report all TPL data as needed by the Bureau.

A.3.12.2.33 Update system and operations documentation when system changes are made.

A.3.12.2.34 Maintain the capability for the TPL system to meet the federal requirements for MMIS certification; and 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 must be verified to be one hundred percent (100%) accurate and must interface with the Financial Accounting system.

A.3.12.2.35 Develop and maintain functionality to process files received from a collection agency and reverse claims that have been recouped.

A.3.12.2.36 For certification, ensure that the system is capable of storage and retrieval of required TPL information.

A.3.12.2.37 Maintain functionality to ensure that the system correctly applies appropriate settlement payments to claims.

A.3.12.2.38 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.3.12.2.39 Provide dedicated onsite Medicaid knowledgeable staff with specific knowledge of TPL and federal regulations to perform TPL maintenance and modification work requests; this staff to become knowledgeable of the requirements specific to the Bureau and the TennCare TPL program.

A.3.12.2.40 Modify and maintain the TPL Case Tracking system, as directed by the Bureau.

A.3.12.2.41 Generate TPL data to MCCs on a schedule defined by the Bureau.

A.3.12.2.42 Process billing of UBs and HIC claims to insurance carriers.

A.3.12.2.43 Operate Case Tracking for Estate/Casualty Case development.

A.3.12.2.44 Assess the entire interchange TPL system and review with Bureau TPL unit to identify any possible changes or enhancements.

A.3.12.3 Revised or New TPL Contractor Requirements

The following requirements are functionalities that shall be developed and implemented by the Contractor after Bureau approval.

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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 must 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

TPL Interface	Entity/ Vendor	Input/ Output	Freq	Media	Info/Description	File Layout
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
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

TPL Interface	Entity/ Vendor	Input/ Output	Freq	Media	Info/Description	File Layout
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 as it relates 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.

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 which an eligible recipient may be active for 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. Reference 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, 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 (for example, 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 services provided. Procedure codes are designed around a five (5) character coding format defined by the Centers for Medicare & 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.3.13.1.8.1 HCPCS Codes

Defined by the Centers for Medicare & 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.3.13.1.8.2 CPT-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.3.13.1.8.3 Dental 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 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 of TennCare 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; HCPCS modifiers; and 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 will 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 of TennCare.

A.3.13.2.35 Ensure that only authorized personnel can 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; describing 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 MAC, 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 daily Reference file update reports 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 should 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 of TennCare 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 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 must 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), diagnosis-related groups (DRGs), 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. NDC, GCN, HICL, Diagnosis, Revenue).

A.3.13.3 Revised or New Contractor 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 must 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.
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	CIGNA	Input	Annually	CIGNA provides Medicare pricing updates. This file contains pricing updates for prosthetic and orthotic

Reference Interface	Entity/ Vendor	Input/ Output	Freq	Destination/Info/Description
orthotics)				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.
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 of All-inclusive Care for the Elderly) program (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 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

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) via 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 Support functionality to track LTC activities, such as complaints, appeals, compliance issues, and PAE status, and produce a summary level report for LTC management.

A.3.14.3.6 Maintain functionality to process capitated payments for PACE enrollees

according to the admit date, or as specified by the Bureau.

A.3.14.3.7 Maintain process to assign unique provider numbers for LTC providers.

A.3.14.3.8 Maintain functionality to accept, store and retrieve PAE data.

A.3.14.3.9 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.3.14.3.10 Maintain functionality to accept claims directly from waiver service providers.

A.3.14.3.11 Maintain functionality to accept claims with reassignment of payment to the HCBS programs.

A.3.14.3.12 Maintain functionality to track and report on MCO/BHO encounters of LTC enrollees.

A.3.14.3.13 Maintain functionality to accept all claims from all provider types electronically.

A.3.14.3.14 Track and report on PAE status and produce an aging report for prioritization (work flow management).

A.3.14.3.15 Maintain the database to share waiver information between multiple State agencies, including data extracts and online queries.

A.3.14.3.16 Maintain the capability to accept PAE via electronic submission and return of PAE with an attached summary of findings.

A.3.14.3.17 Maintain functionality to track and report on PAE and PAE appeals in-house including dispositions.

A.3.14.3.18 Maintain the functionality to store PAE history information electronically.

A.3.14.3.19 Maintain functionality to generate PAE approval/denial notices.

A.3.14.3.20 Maintain functionality to retain PAE approval/denial letters in the system for easy online retrieval.

A.3.14.3.21 Track and report the status of PAE submitted for waiver programs (e.g. waiting lists, crisis/urgent/active/deferred/DHS estate recoveries, DMRS lists) upon request by users.

A.3.14.3.22 Maintain functionality to accept, track and report Long-Term Care and waivers service appeals, to include, but not limited to:

A.3.14.3.22.1 Online access to appeals information;

A.3.14.3.22.2 Functionality to report status information;

A.3.14.3.22.3 Maintain Recognition Research Imaging (RRI) images of all appeals information;

A.3.14.3.22.4 Archive, and facilitate online viewing and retrieval of cases;

A.3.14.3.22.5 Support access of all PAE;

A.3.14.3.22.6 Encounter/claims history relating to the appeal and track by enrollee all appeals filed with decisions made by staff and administrative law judges;

A.3.14.3.22.7 Support all "Alerts" of staff when an appeal deadline is approaching; and

A.3.14.3.22.8 Generate standard notices, appeal acknowledgement and decision notices to enrollee, enrollee's designee and the service provider.

A.3.14.3.23 Maintain edits for inputs (PAE and TAD-like claims) to ensure consistency and validity of information received through online data entry.

A.3.14.3.24 Maintain system to process Preadmission Evaluation (PAE) processing real-time, and to edit Claims with associated PAE data.

A.3.14.3.25 Ensure that the mandated annual CMS-372 report is generated according to the scheduled date due.

A.3.14.3.26 Operate and maintain the Long Term Care tracking components of the interChange TCMIS for institutional and waiver programs.

A.3.14.3.27 Maintain a file/database of services provided to institutional and waiver program participants.

A.3.14.3.28 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, Shelby County Senior Services, the Pace provider, DHCF, the Comptroller Office, the State Patient Care Advocate, MCCs and other State Contractors.

A.3.14.3.29 Perform online eligibility changes to ensure appropriate processing of Long Term Care and waiver program claims.

A.3.14.3.30 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 should receive the same unique number as the document to which it is attached.

A.3.14.3.31 Maintain function to image claims and any attachments. Process/archive every claim and attachment within one (1) business day of receipt.

A.3.14.3.32 Maintain data entry keying accuracy standards of ninety-nine percent (99%) for claims and other transactions.

A.3.14.3.33 Maintain capability to accept online real time submission of TAD-like claims and encounter data, via portal entry twenty-four hours per day seven days per week (24/7).

A.3.14.3.34 Assign a unique claim reference number upon entry into the TCMIS interChange system.

A.3.14.3.35 Load claims submitted electronically to the claims engine within one (1) business day of receipt.

A.3.14.3.36 Process, edit, and adjudicate claims and encounters a minimum of five (5) times per week or as directed by the Bureau of TennCare.

A.3.14.3.37 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 via EDI shall be processed within twenty-one (21) calendar days. One hundred percent (100%) of clean claims that are received via paper shall be processed within thirty (30) calendar days, or according to Bureau requirements.

A.3.14.3.38 Maintain 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.3.14.3.39 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.3.14.3.40 Return claims or attachments missing required or unreadable data within one (1) business day of receipt. Any attachments must be returned with the claims. Instructions for the providers on how to correct and resubmit the returned claims must be included when the claims are returned to the provider and tracked via an audit trail. All claims correspondence sent to and received from providers must be imaged and associated with the provider's record. All correspondence must be stored and retrievable online upon authorized user demand.

A.3.14.3.41 Support the functionality to update claims data resubmitted by providers, within three (3) business days of receipt.

A.3.14.3.42 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 should 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 should also be made available via web portal if requested by authorized users.

A.3.14.3.43 Generate and submit claims and encounter inventory and operations reports after each claims/encounter processing cycle.

A.3.14.3.44 Maintain functionality to update the claims and encounter entry files daily, or as received.

A.3.14.3.45 Provide retrieval of hard-copy claim documentation/correspondence image upon user request.

A.3.14.4 Revised or New Contractor 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 of TennCare policies and/or rules in order to process LTC claims, (e.g. compute appropriate eligibility dates (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.

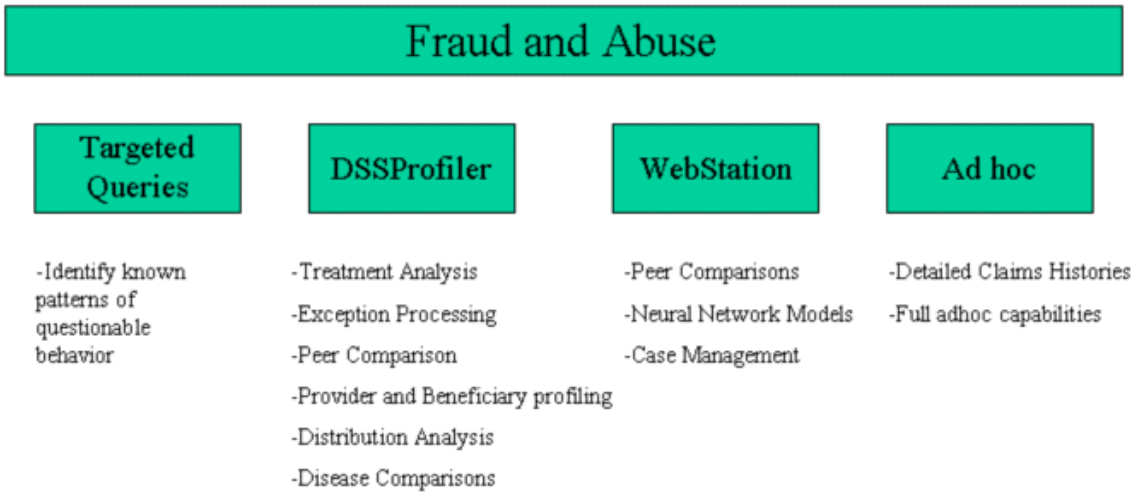
A.3.14.5.2 Provide information to the Contractor about changes to Long Term Care and Waiver programs so that notices may be generated to enrollees and families or caregivers.

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

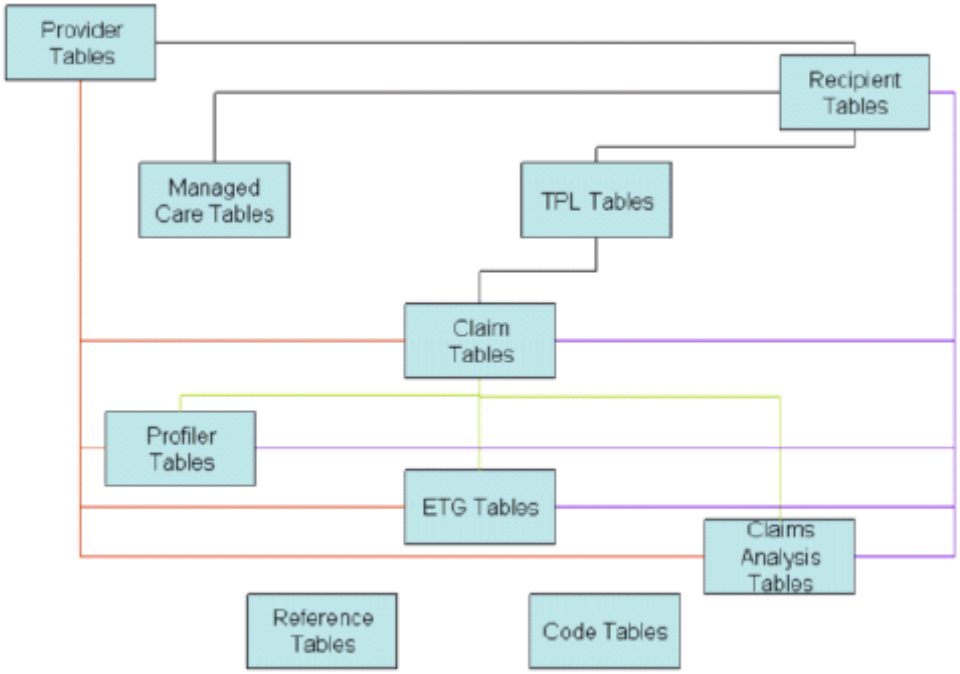
The SUR functional area of the TCMIS is used to monitor both fee-for-service and encounter claims processed by the Bureau of TennCare for fraud and abuse by providers and recipients. All requirements of a SUR subsystem must continue to be maintained and updated as required by the Bureau.

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 four (4) components: Targeted Queries, DSSProfiler, WebStation, and Ad Hoc reports.

The diagram below depicts the Fraud and Abuse components:



The following data model has been simplified to only show tables contained within the Fraud and Abuse subsystem area. Fraud and Abuse is related to many entities including Eligibility, Provider, Reference, and Claims. Additionally, there are other Fraud and Abuse tables for external interfaces and data consolidation. A comprehensive Fraud and Abuse data model would be too large and complex to be graphically displayed.



A.3.15.1 SURS Contractor Requirements

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 of TennCare 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, DEA number, NCPDP number, UPIN number, 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 of TennCare's instructions.

A.3.15.1.12 Maintain the SUR subsystem according to federal MMIS GSD certification requirements and all Bureau requirements.

A.3.15.1.13 Maintain SURS selection criteria based on input prepared by the Bureau of TennCare.

A.3.15.1.14 Produce and distribute SUR reports as required by the Bureau of TennCare.

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 must 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
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 of TennCare contracts with several Managed Care Organizations (MCOs), and contract arrangements with each may vary. Most of the MCOs provide all physical health care services, except for behavioral health, long term care, dental, and pharmacy services, while others provide all physical health care services *and* behavioral health services, but with exception to long term care, dental, and pharmacy services.

With the exception of enrollees assigned to the aforementioned MCOs who provide both physical and mental healthcare, most TennCare enrollees receive behavioral health services through the TennCare Partners program. Under this program, contracted Behavioral Health Organizations (BHOs) provide covered mental health and substance abuse treatment 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 of TennCare's 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 OGC 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 of TennCare 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 issue 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 Pharmacy Benefits Manager and Dental Benefits Manager, 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 - for example: contracts with State agencies such as DCS (Department of Children's Services)
- 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).

Qualified Medicare Beneficiaries (QMBs) and Special Low Income Medicare Beneficiaries (SLMBs) do not participate in TennCare Medicaid if it is the only eligibility category they qualify for.

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), who are not enrolled with a MCC.

A.3.16.3 MCO/BHO (MCC) Assignment Distribution Process

TennCare enrollees are assigned to an MCO that provides health care services and a BHO 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 of TennCare, 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: Babies (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 can 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 which 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 which 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 which 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; and provides 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 of TennCare's business areas:

- 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 MAR Contractor Requirements

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 of TennCare 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 will 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 will 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; 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 is 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
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 of TennCare is 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 must meet the State's geographical access standards, as well as adhere to the following provider network guidelines:

A.3.18.1.1 Networks must include specified safety net providers for specified safety net services;

A.3.18.1.2 Networks must include at least one (1) Centers of Excellence for individuals with HIV/AIDS in each of the Grand Regions in which the MCO participates;

A.3.18.1.3 Networks must include Centers of Excellence identified through the State's EPSDT program for treatment of children in State custody;

A.3.18.1.4 Networks must 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 must demonstrate that its network is adequate and must ensure that it has the needed capacity and range of services for vulnerable populations;

A.3.18.1.6 MCOs must 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 must 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 of TennCare is responsible for Provider Enrollment, Provider Credentialing, Provider Relation functions and Network Management.

A.3.18.2.1 Provider Enrollment

The Bureau of TennCare 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 of TennCare 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. Currently the Provider Enrollment Unit assigns a unique number to each Medicare provider before a crossover claim can be billed to the Bureau of TennCare. TennCare only providers are also assigned a unique TennCare provider number. These providers include, but are not limited to, pediatricians, OB, pharmacy, 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. Each BHO assigns a unique provider number to each of their contracted providers.

Providers are 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 of TennCare 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 of TennCare Medical Director; to verify required licenses and certifications, including specialty credentials. If Medicare has issued a Medicare provider number then the Bureau of TennCare automatically enrolls the provider. Each contracted MCC plan is currently responsible for credentialing their providers. The Bureau of TennCare does not currently track and report license and contract renewal status. Currently 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 of TennCare sends a letter to the MCC detailing the issues and a corrective action plan is required for correcting network deficiencies. The Bureau of TennCare 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 hours per day, seven days per week (24/7), 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 must supply providers and Managed Care Contractors (MCCs) with the necessary information for appropriate care of TennCare members. In some cases, information can 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 fax.

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 will 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 twenty-four hours per day, seven days per week (24/7) via 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, 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 must 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 of TennCare, 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 of TennCare.

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 of TennCare.

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 of TennCare 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 Conduct provider training sessions, 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 will 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 Revised or New Contractor Requirements

The following requirements are functionalities that shall be developed and implemented by the Contractor after Bureau approval.

A.3.18.6.1 Provide 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 is 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

Interface Provider Subsystem	Entity/ Vendor	Input/ Output	Freq	Destination/Info/Description
				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, 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 via 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 of TennCare 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 of TennCare's requirements for electronic banking, including electronic funds transfer and compliance with the Federal Cash Management Improvement Act. The TCMIS also supports the Bureau of TennCare'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 and additional information can also 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 EDI Contractor Requirements

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; ensuring compliance with HIPAA electronic data interchange standards.

A.3.19.1.2 Provide information via web or VPN connectivity to providers, contractors and business partners regarding eligibility status for the date queried; 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 via 997 or other Bureau approved feedback documentation.

A.3.19.1.7 Provide, and update as appropriate, a back-up translator system to ensure that no system downtime (due to hardware or software problems) occurs.

A.3.19.1.8 Maintain and support internet accessibility and transaction processing via 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 via 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 per day, seven days per week (24/7) 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 training, assistance and help desk support to providers, business partners, enrollees, Bureau personnel, and other end-users on the various inquiry functions, such as AVRS, as needed, regardless of geographic location.

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.

A.3.19.1.15 Transmit 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

will ensure 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 hours per day, seven days per week (24/7).

A.3.19.1.18 Provide operator assistance in using the electronic commerce functions from 7:00 a.m. to 10:00 p.m. Central Time, Monday through Friday. Provide operator assistance on weekends and Bureau of TennCare approved holidays from 8:30 a.m. to 5:30 p.m., Central Time.

A.3.19.1.19 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.3.19.1.20 Notify the Bureau of TennCare immediately when the inquiry system is down.

A.3.19.1.21 Notify all business partners immediately when EDI functionality is down.

A.3.19.1.22 Operate the electronic transaction component of the TCMIS, including improvements/enhancements as they are implemented.

A.3.19.1.23 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.3.19.1.24 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.3.19.1.25 Provide appropriate staff to handle both technical and informational responsibilities concerning electronic transaction functions.

A.3.19.1.26 Perform online, real-time logic and consistent editing of claims transmitted by the providers.

A.3.19.1.27 Ensure that all online edits conform to TCMIS edit structures and outcome dispositions.

A.3.19.1.28 Maintain functionality to perform necessary logic and consistent editing for all submitted claim/encounter claim data.

A.3.19.1.29 Provide online notification to submitters, shortly after transmission, regarding any transmission or claim data errors, or acceptability for further processing.

A.3.19.1.30 Maintain control and tracking standards for claims submitted electronically.

A.3.19.1.31 Produce all defined and Bureau approved reports regarding electronic claims submissions.

A.3.19.1.32 Support 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.

A.3.19.1.33 Maintain functionality to assign transaction control numbers to electronic claims immediately upon acceptance.

A.3.19.1.34 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.3.19.1.35 Update system and operations documentation when system changes are made.

A.3.19.1.36 Provide onsite staff for management and support for the TCMIS translator.

A.3.19.1.37 Support interactive processing of the ANSI X12N 278 Health Care Prior Approval Transaction when submitted.

A.3.19.1.38 Implement, maintain, and support new EDI standards, as directed by the Bureau.

A.3.19.1.39 Process 997s received by TennCare for TennCare submitted transactions and immediately notify TennCare electronically of any 997 that is not fully accepted by the receiver.

A.3.19.2 EDI Inputs and Outputs

The Input and Output files for EDI are standard X12, NCPDP, HL7 files and proprietary files. The Companion Guides can be found at: http://www.state.tn.us/tenncare/HIPAA/EDI.htm.

A.3.19.3 EDI Bureau Responsibilities

A.3.19.3.1 Review and approve all operating policies and procedures.

A.3.19.3.2 Facilitate working 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 in the facility located at 310 Great Circle Road, Nashville, TN., where the State will provide the following facility related items:

1) Utilities (electricity and water)
2) Local Area Network (LAN) Connectivity
3) Workstations for technical and support staff
4) Janitorial services
5) General facility security
6) Fire alarm and/or fire suppression system
7) Standard office furniture, (e.g. desks, chairs, wall panels, shelves, file drawers).

The Contractor will be responsible for providing the following:

1) Copiers, fax machines, personal office equipment
2) Provide any additional office equipment or landscaping, if desired.
3) Expendable supplies for Contractor staff
4) Liability insurance for Contractor staff and equipment.

Telephones will be provided by the State, using the following rates:

a) Monthly service charge per set: $6.38
b) Long Distance for intralata per minute - $0.072
c) 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 of TennCare 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 of TennCare for approval. In addition, the Bureau of TennCare prior to implementation shall approve major schedule modifications. If required for completion of TCMIS processing, production control and scheduling functions may operate twenty-four hours per day, seven days per week (24/7) until completed. In the event production control and scheduling functions are not required for a specific period, the Contractor will provide on-call support as agreed upon between the Bureau of TennCare 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 must maintain the Edifecs SpecBuilder, XEngine and Transaction Manager software.

A.3.20.1.1.5 The Contractor must correctly apply/upgrade to the most current version of Edifecs SpecBuilder, XEngine and Transaction Manager software, as approved in writing by the Bureau.

A.3.20.1.1.6 The Contractor must 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 of TennCare business processes.

A.3.20.1.1.7 The Contractor must 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 of TennCare.

A.3.20.1.1.8 The Contractor must 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.3.20.1.1.9 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- 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 weekly 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 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 period the hardware environment for Interchange needs to be upgraded, the Contractor will 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 of TennCare 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 should 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 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 Mailroom

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 of TennCare forms and distribute to providers, MCCs and other entities upon request.

A.3.20.1.2.3 Open, sort, and distribute all Bureau of TennCare mail beginning on January 1, 2009, and as subsequently received during the term of the 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 of TennCare 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 of TennCare policies and procedures.

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 of TennCare's approved production schedule. All outputs are to be delivered as identified in this Contract unless otherwise agreed upon between the Bureau of TennCare and the Contractor in agreed media, format and number of copies.

A.3.20.1.3.6 Provide to Bureau of TennCare 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 of TennCare for all aspects of the TCMIS; assist the Bureau of TennCare 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 of TennCare 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 of TennCare.

A.3.20.1.5.6 Produce and assist Bureau of TennCare 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 of TennCare, 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 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.

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 System Support

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 of TennCare.

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 of TennCare's Nashville facility during the operational period.

A.3.20.1.6.5 Identify and inform the Bureau of TennCare 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 of TennCare 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 the Contract to the extent and in such detail as shall properly reflect conformance with the Contract and meet federal and Bureau record retention requirements; and 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 the Contract.

A.3.20.1.6.9 Provide the Bureau of TennCare 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 hours per day, seven days per week (24/7).

A.3.20.1.7 EQRO

A.3.20.1.7.1 Provide data needed for the EQRO contractor.

A.3.20.1.8 Training

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: develop, implement, and maintain 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 Forms Management

A.3.20.1.9.1 The Contractor shall provide and maintain, at all times, an inventory of all forms that will meet all mailing and distribution requirements of the Bureau of TennCare related to this Contract. In addition, the Contractor shall provide and maintain a ninety (90) day supply of all forms throughout the Contract period. 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 of TennCare or its designee on the ending date of the Contract.

A.3.20.1.9.2 The Contractor shall provide and maintain the flexibility throughout the 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 of TennCare. All changes shall be made at the direction of and be approved by the Bureau of TennCare. The Contractor should 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 per standard business practices, not performing per 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 of TennCare 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 must begin early during the transition to ensure timely delivery, if necessary, of test data to the Bureau or other Bureau-designated personnel. During transition delivery schedules shall be determined by the Bureau. This service shall include delivery of documents and materials to and from locations in the Nashville area designated by the Bureau of TennCare. 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 of TennCare responsibilities, which are necessary for the operation and maintenance of the TCMIS including scheduling and maintaining regular executive leadership meetings between the Bureau of TennCare'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 will 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 must prepare updates to the interChange TCMIS Systems Documentation incorporating all changes, corrections, or enhancements to the TCMIS. Updates to the TCMIS Systems Documentation must 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. Central Time. 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. Monday through Friday and on weekends. Production control personnel shall be accessible twenty-four hours per day, seven days per week (24/7).

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 of TennCare approval of work on change requests. It is the Bureau's expectation that all modification activity will be accomplished within the budgeted effort and that all hours of modification work will 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 the 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 Resource management: 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 life of the 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 does not adequately support the duties of their position.

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 Testing

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 must 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 must 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 will 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. 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 will 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 of TennCare 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 will establish a joint security management team to accomplish these objectives.

A.3.20.1.19.3 Treat all information obtained through Contractor performance under the 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, will have access to all confidential information in accordance with the requirements of State and federal laws and regulations. The Bureau will 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 Change Management/Software Configuration Management

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 standard build management tools, Serena® Builder and Version Manager, by the Operations start date of 01/01/2009.

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 will use the Bureau's TeamTrack system for documenting all change requests. Additionally the Contractor will work 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;

e) Utilize migration procedures for moving multiple projects into production involving common software modules;

A.3.20.1.20.17 The Contractor must document and have well defined procedures that are consistent with industry and State standards for the following:

a) Version Manager: 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 will 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 must 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 must 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 must 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 of TennCare has embarked on building an Information Management System that will 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 of TennCare has provided its enrollees the ability to contact the Bureau and access information through the use of an automated call management system.

The, the Bureau of TennCare 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 of TennCare. 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

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.

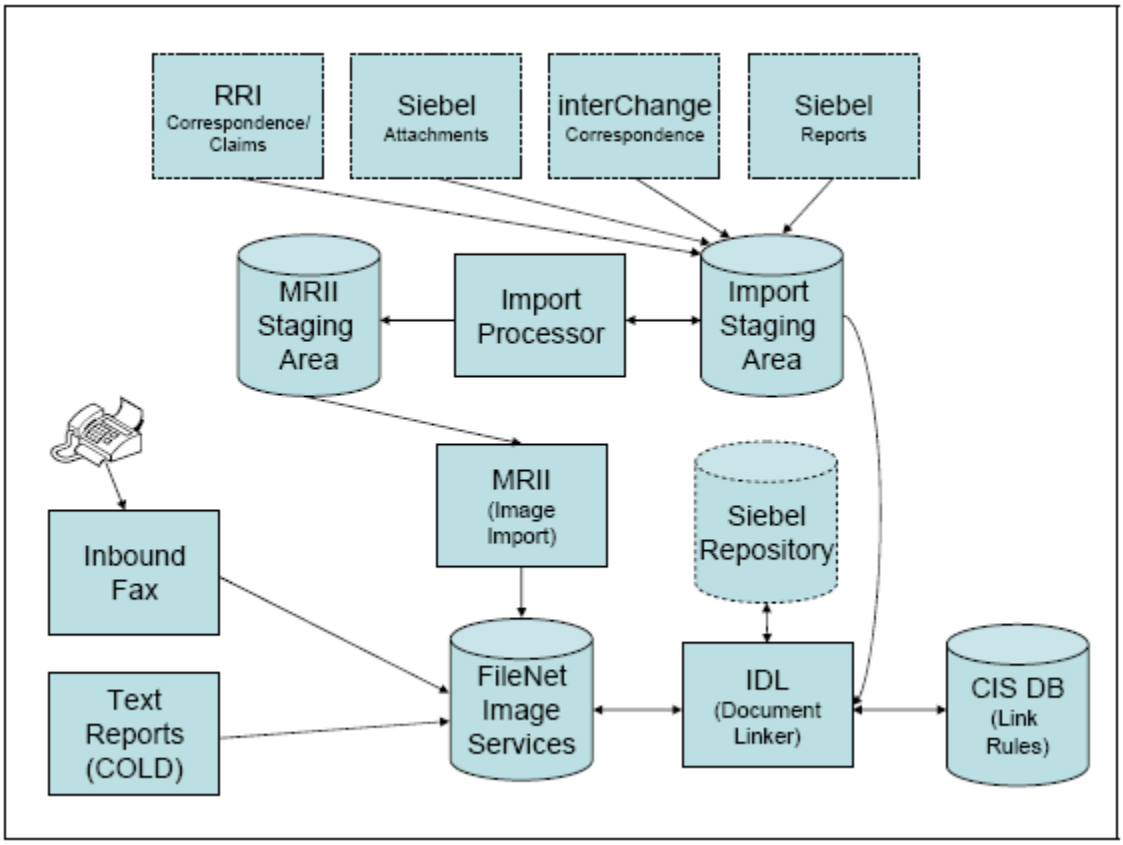
A.3.20.2.3 Document Imaging, Storage and Retrieval Contractor Requirements

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 is 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- 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 of TennCare 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 will not affect the terms of this Section of the 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 Production Server Support

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 the Claims Adjudication Manual to ensure procedures meet the intent of Bureau of TennCare 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 8,100 suspended claims per week. Although this is the projected suspended claims volume, the Contractor should allow for volume fluctuation up to 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 Develop and 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, according to the standards set by CMS. Ninety Percent (90%) of all clean claims will be processed to a disposition outside the Contractor's responsibility within thirty (30) days of receipt. One Hundred Percent (100%) of all clean claims will be processed to a disposition outside the Contractor's responsibility within sixty (60) days of receipt. One Hundred Percent (100%) of all clean claims will be processed to a disposition outside the Contractor's responsibility within 30 days of receipt.

Complete any backlog of suspended claims within ninety (90) days of Contractor receiving the Bureau's approval of the adjudication guidelines for each edit.

A.3.20.6 Member Services

A.3.20.6.1 Member Services Contractor Requirements

A.3.20.6.1.1 Maintain the CTS system 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 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 Generate an audit trail and identify the CSR who responded to the call.

A.3.20.6.1.8 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 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 will be accessible to all authorized entities.

A.3.20.6.1.16 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 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, fax, 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 of TennCare.

A.3.20.6.1.27 Provide the Bureau of TennCare 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 hours per day, seven days per week (24/7).

The Contractor shall respond to Level two (2) 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 via, in person visit, telephone conversation, voicemail message, or email.

The table below depicts the required response times:

Level	Response Time in business hours
2	24 hours
3	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 2 and Level 3 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 Facilities Manager 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 Facilities Manager Contractor.

A.3.20.7.3 Provide at least three (3) business days notice to the Facilities Manager 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 Facilities Manager 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 State Comptroller 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 will 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 will 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 will 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 TennCare 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 TennCare 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 Facilities Manager'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 TennCare 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 Produce and mail annual ballots, or as directed by the Bureau of TennCare.

A.3.20.11.1.10 Process all returned mail, including ballots, received from enrollees and providers.

A.3.20.11.1.11 Provide local hardware and software maintenance, with reasonable expected response time for service calls.

A.3.20.11.1.12 Scan, image, index and route all documents and correspondence received within twenty-four (24) hours of receipt, as defined by the Bureau.

A.3.20.11.1.13 Document and route documents with failed and indexing standards to a designated end user for resolution within twenty-four (24) hours, or as defined by the Bureau.

A.3.20.11.1.14 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.3.20.11.1.15 Provide the functionality to support Document Imaging, Storage and Retrieval applications.

A.3.20.11.1.16 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.3.20.11.1.17 Provide software-training sessions for Bureau staff, contractors, and other State agencies when requested by the Bureau.

A.3.20.11.1.18 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.3.20.11.1.19 Produce all required operations reports, and make available online or deliver to the Bureau within established time frames.

A.3.20.11.1.20 Produce reports and make available online or deliver to the Bureau all required federal and State financial reports within established time frames.

A.3.20.11.1.21 Produce reports necessary for the Bureau to monitor accounts receivable, liens, recoupments, and other financial transactions.

A.3.20.11.1.22 Maintain security for restricted access objects at all times.

A.3.20.11.1.23 Report any security violations or attempted security violations immediately to the Bureau of TennCare.

A.3.20.11.2 Revised or New Contractor 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 must 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 the 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 must 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 must 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.

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 must 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 must include a proposed approach to the turnover, a requirements statement, and a schedule including tasks and sub-tasks. The Turnover Plan must also include all TCMIS production data, program libraries, resource inventory, software, and all associated documentation.

A.3.21.1.1 The Turnover Plan must 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

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 must ensure that the TCMIS will be error free and complete when turned over to the Bureau or the successor Contractor. If not, the Contractor must 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 of TennCare, their designee, or the successor Contractor.

A.3.21.3.2 The Contractor must cooperate with the successor Contractor while providing all required turnover services. This will 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 must 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.3.21.4.1.2 The Contractor must provide a detailed organizational chart depicting the Contractor's total TCMIS operations resources.

A.3.21.4.1.3 Turnover Staff Requirements:

The Contractor must provide the following dedicated staff with appropriate job skills as follows to support turnover activities:

Turnover	At least three (3) years MMIS experience and experience

Manager	turning over operations similar in size and scope

The Turnover manager may serve part-time until the Bureau of TennCare initiates a request for the turnover activities to begin, then this person shall devote one-hundred percent (100%) of time to turnover activities until contract ends.

The Contractor must 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 must 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.3.21.4.2.1 Data processing and imaging equipment

A.3.21.4.2.2 Technical environments used

A.3.21.4.2.3 All testing environments

A.3.21.4.2.4 Applications, environments and functions

A.3.21.4.2.5 System and special software applications

A.3.21.4.2.6 Telecommunications circuits (voice and data)

A.3.21.4.2.7 Imaged documents stored on optical and magnetic media

A.3.21.4.2.8 Production or those used as production computer programs

A.3.21.4.2.9 Production scripts, routines, control language and schemas

A.3.21.4.2.10 Operations logs, balancing documents, and process summaries.

A.3.21.4.3 Turnover of Documentation

The Contractor must 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.3.21.4.3.1 User documentation

A.3.21.4.3.2 Operations documentation

A.3.21.4.3.3 System documentation, (e.g. including procedures for updating computer programs)

A.3.21.4.3.4 Procedures documentation

A.3.21.4.3.5 Training documentation

A.3.21.4.3.6 Data dictionary

A.3.21.4.3.7 System configuration diagrams

A.3.21.4.3.8 BCCP and Recovery procedures

A.3.21.4.4 Turnover Training Activities

A.3.21.4.4.1 The Contractor must provide training to the successor staff in the operation of the TCMIS infrastructure. Such training must be completed at least six (6) months prior to the end of the 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.3.21.4.4.2 If 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.3.21.4.5.1 Outstanding/unprocessed paper claims

A.3.21.4.5.2 All paper files

A.3.21.4.5.3 ME 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; (2) Other Work Inventory

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 will be turned over to the Bureau at Contract conclusion.

A.3.21.4.6.2 The Contractor must 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 will 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 will be the point of contact during the Turnover activities, and will 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 TCMIS 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 paragraph A.3.21.4.2.).

A.4 Change Management

A.4.1 Operations Phase Maintenance Tasks

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

All TCMIS functions must 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 after its implementation, as directed by the Bureau. It is the Bureau's expectation that all maintenance requirements shall be accomplished under the terms of the 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 must 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 which it was approved;

A.4.1.1.2 Activities necessary to modify the system to meet the requirements detailed in this Contract;

A.4.1.1.3 Activities necessary to ensure that all data, files, and programs are current and that errors are corrected;

A.4.1.1.4 Activities necessary to meet CMS certification requirements which exist at the time of Contract start date;

A.4.1.1.5 Activities related to file growth and partitioning;

A.4.1.1.6 File maintenance activities for updates to all files;

A.4.1.1.7 Scheduled ongoing tasks to ensure system tuning, performance, response time, database stability, and processing;

A.4.1.1.8 Changes to the JCL (or JIL), or system parameters concerning the frequency, number, and media of reports or data feeds;

A.4.1.1.9 Updates to software, operating systems or other system components requiring

version updates, manufacturer 'patches' and other routine manufacturers' updates to software;

A.4.1.1.10 Addition of new values and changes to existing system tables and conversion of prior records, as necessary;

A.4.1.1.11 Fixes for something that does not work according to requirements;

A.4.1.1.12 Entry of all system lists, parameters, and other table updates;

A.4.1.1.13 Performing the activities requested by the Bureau via the official transmittal process;

A.4.1.1.14 Activities necessary to ensure that all data, files, and programs are current and that errors are reduced; and

A.4.1.1.15 Activities to ensure the most current technology (system hardware, software upgrades) is refreshed and included in the TCMIS throughout the life of the Contract.

A.4.1.2 System Maintenance Team Staffing Contractor Requirements

The Contractor shall provide sufficient staff to perform all systems maintenance responsibilities. These individuals are separate and distinct from those for modification support. They 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 should include a summary of hours worked by staff by maintenance task.

The Maintenance and User Support Staff should include, but not be limited to, the following job descriptions as defined by the Contractor.

The table below lists the required Contractor Maintenance Support Staff:

Staff Description
Information Specialist - Senior
Information Specialist
Information Analyst
Information Associate
Business Services Analyst - Senior
Business Services Analyst - Advanced
Business Services Analyst
Technical Delivery Team Manager
Project Manager
Project Analyst – Senior
Project Analyst – Advanced
Project Analyst
Data Base Administrator
Data Base Associate
Infrastructure Specialist Senior
Systems Administrator - Advanced
Systems Administrator

Staff Description
Systems Administrator - Associate
Computer Operator
QA Specialist – Advanced
QA Specialist
Technical Writer
Specialized Support Clerk
General Support Clerk
Release Coordinator
Change Management Coordinator
Work Planner

A.4.1.3 Maintenance Task Activities

All system maintenance activities that address system deficiencies must be completed within the following timeframes. Within five (5) business days of discovery or receipt of a deficiency notification, the maintenance staff shall submit a Corrective Action Plan (CAP) to the Bureau for review indicating how the deficiency will be corrected. The correction will apply to both systemic and processing/operational issues. Bureau staff will review and approve or return the CAP to the Contractor for modification within five (5) working days. The CAP will include information that will define any system and/or operational problem, the problem solution, and the level of effort required to code, test, implement, address operational issues and update documentation related to the deficiency. Once approved by the Bureau, the Contractor shall correct the deficiency within ten (10) business days unless the Bureau has granted an extension of the period of time necessary to cure the deficiency.

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

In addition, the Contractor will 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 a maintenance team 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.4.1.4.2 Notify Bureau when operational problems occur;

A.4.1.4.3 Submit Corrective Action Plans regarding all deficiencies;

A.4.1.4.4 Perform all activities relative to the correction of deficiencies within the time-frames stated in the Contract;

A.4.1.4.5 Organize and provide status and associated information during daily, weekly, and monthly status meetings with the appropriate Bureau staff to monitor current operations and to monitor progress of maintenance activities;

A.4.1.4.6 Document weekly status meetings as meeting minutes, and provide 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 identified, within one (1) business day of discovery;

A.4.1.4.13 Enter the work request identifying the maintenance support into TeamTrack;

A.4.1.4.14 Present the Bureau with a Corrective Action Plan for approval within five (5) business days of discovery, unless otherwise specified by the Bureau;

A.4.1.4.15 Submit test plan, including testing responsibilities, when required by the Bureau;

A.4.1.4.16 Conduct unit test;

A.4.1.4.17 Conduct systems test in coordination with Bureau staff;

A.4.1.4.18 Present test results to the Bureau;

A.4.1.4.19 Conduct integrated (regression) test in coordination with Bureau staff;

A.4.1.4.20 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.4.1.4.21 Implement Corrective Action plans upon Bureau approval;

A.4.1.4.22 Verify the successful implementation of the correction, including monitoring accuracy of processing, and correction of any problems;

A.4.1.4.23 Assure all daily, weekly, monthly, quarterly, annual and on request cycles are run correctly and on time;

A.4.1.4.24 Perform work as instructed in official transmittals. This may include extracting data from archived files;

A.4.1.4.25 Perform research immediately upon recognizing potential system problems in order to minimize system or payment impact and improve processing;

A.4.1.4.26 Submit reports of system errors and failures within one (1) business day of the occurrence;

A.4.1.4.27 Proactively maintain and upgrade all hardware and software to support Contract

uptime and response time; and

A.4.1.4.28 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 should 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 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 weekly 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; and

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 the Contract. This section of the Scope of Work describes how future changes or improvements to the system will 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 must 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 start date of this contract, there is an existing workload of (SCRs) that must continue to be addressed under the new Contract term. The new Facilities Manager will 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 will be responsible for the production of all APDs.

A system modification exists when program source code must be changed to implement a system functional or performance requirement beyond the system requirements. However, if source code changes merely involve adding, changing, or deleting data element values incorporated in the source code or used by the source code, the change is considered maintenance. Further, to the extent that existing edits and audits use values contained in the source code (compile-able code or “hard-coded”), changes, including deletions and additions to the valid values in the source code, will also be considered maintenance.

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 (the Bureau calls changes, updates or modifications to the system an enhancement, not to be confused with the seven (7) Enhancements outlined in this Contract), will be made using a standard Systems Development Life Cycle (SDLC), as approved by the Bureau. Examples of a modification include the following:

a) Functionality not specified in this Contract or agreed to during the Enhancement Phase;

b) Implementation of edits and audits not defined in the system installed for operations;

c) A system modification to established reports, screens, or files formats; new data elements; or report items;

d) Activities necessary to meet new or revised CMS requirements; and

e) Activities necessary to meet new or revised 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 must coordinate with the Bureau to use TeamTrack. TeamTrack must 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 will also include a three (3) month projection of the SCRs that will be implemented in each month. Major projects, requiring more than three (3) months to complete, will 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 will include progress toward that due date by reporting on each project milestone's status.

A.4.2.2 System Modification Team Staffing Contractor Requirements

At a minimum, full-time support for system modifications must be provided on site by:

A.4.2.2.1 TCMIS Systems Manager and adequate professional systems engineering (programmer/analyst) staff shall be responsive to TCMIS Contract requirements.

The minimum qualifications for the Systems Manager are specified in this Contract. The Systems Manager shall serve as the primary liaison between the Modification Team and Bureau staff for all system changes.

The Contractor shall be required to provide and maintain a modification and enhancement staff to perform the system modifications and enhancements of the TCMIS. This staff will be in addition to the maintenance staffing. The staff shall be identified by the Contractor as modification and enhancement staff and shall be assigned to modification and enhancement projects. Additionally, the staff can be assigned to maintenance and support with the approval of the Bureau of TennCare.

The Contractor shall assign all other resources to subsystems or subsystem areas as necessary to perform all system modifications and enhancements of the TCMIS. The Contractor must ensure that all staff members possess the necessary technical background, education, and skills to perform in the various environments necessary to support the TCMIS.

The Contractor will provide a monthly report of time spent by job category for Information Analysts, Business Services Analysts and Project Managers. Based upon the Contractor's staffing levels the minimum number hours are:

Information Analyst/Specialist:	93,810 hours per year
Business Services Analyst:	26,550 hours per year
Project Manager:	10,620 hours per year

Technical Delivery Team Managers (TDTM) and the rest of the Project Management Office (PMO) time including the Work Planner, Release Coordinator, Change Management Coordinator, Project Analyst, and Clerk will not be applied to the minimum hours above. At the end of each State fiscal year the Contractor will provide an accounting of the hours spent by job category during that fiscal year. If the total of a job category falls below the minimum, those hours will be added to the minimum totals for the next year. At the end of the Contract the Contractor and the Bureau will review the total

hours spent versus the minimum commitments. If the Contractor fails to meet the minimum hours the Contractor will refund the Bureau the balance of hours.

Any enhancement that requires services outside of the existing staff will be considered a special project and will be funded and managed separately from the existing staffing and the existing processes. Special Project Support is discussed in Section A.4.3.

The Contractor must have qualified staff available on a timely basis to support modification task activities following Bureau approval of work on system change requests. It is the Bureau's expectation that all modification activity will be accomplished within the budgeted effort and that all hours of modification work will 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 the Contract. Hours remaining shall be carried forward to the next Contract year.

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 will be prioritized and approved (or denied or modified) by the Bureau. The various types of modification support must 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 must respond, in writing, to requests from the Bureau for estimates of system modification efforts and schedule within three (3) business days of receipt, unless specified in the SCR (which may reduce that time frame) or for large project planning (which may increase that time frame). The response shall consist of a preliminary assessment of the effort (number of programmer and business analyst hours) required to complete the change by SDLC stage. Additionally, externally funded projects will require additional staff and will run in parallel so as to not impact enhancement work.

A.4.2.3.3 The Bureau may or may not choose to pursue certain modification requests. For those the Bureau chooses to pursue, the Contractor must prepare a formal design estimate. This estimate will 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. Additional services may be requested by the Bureau and shall be provided on a time and materials, per diem, or other mutually acceptable financial basis as negotiated by project or activity. These activities are anticipated to be in support of State health care initiatives, and may include clerical support to eliminate Bureau backlogs and outreach efforts.

A.4.2.4 Modification Processes

A.4.2.4.1 Bureau approval is required on all modification task change requests to be complete. A change request is 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 initially signed by an authorized Bureau representative(s); or

A.4.2.4.1.3 The modification has been successfully tested and approved by the Bureau or the authorized representative, 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 produced and distributed in final form.

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 Prepare a reasonable estimate of staff effort and schedule, including impact on other projects and priorities.

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 ensure modifications do not affect other areas.

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 weekly 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 which shall include a presentation by the Contractor Systems Manager on system modification activities. The weekly meeting will allow the Contractor to report progress against schedules and any necessary schedule revisions, and should 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 modifications 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 must 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 A breakdown of the work effort by milestone;

A.4.2.5.40.3 A breakdown of the work effort by hour within each job classification required;

A.4.2.5.40.4 An implementation schedule for the change request; and

A.4.2.5.40.5 A justification for the additional staff, rates, and schedules.

A.4.2.6 Modification Task Bureau Responsibilities

A.4.2.6.1 Participate in weekly 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 weekly 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 the 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 the 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 will require changes to the TCMIS and business processes. The Contractor must be aware of these upcoming initiatives and be prepared to address the future needs. Refer to RFP Attachment 6.10.1.

A.4.3.2.1 The Contractor must 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 must identify possible future requirements associated with these initiatives.

A.4.3.2.3 The Contractor must identify possible future initiatives not already identified in the Contract that will have an affect on the Bureau of TennCare operations. The Contractor must 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 must be established and maintained during Operations. Version control procedures and update schedules must be used to facilitate tests, track discrepancies and facilitate regression test analysis. The Contractor must 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 must 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 must 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 must create and execute a Bureau-approved test plan for each change request before the change request is implemented.

A.4.4.2.2 Conduct repeatable testing in accordance with written processes and procedures approved by the Bureau. The processes and procedures will not be changed without prior approval by the Bureau. Test plans will 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 must 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 will be given to the Bureau for review and approval.

A.4.4.2.4 Implementation will 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 TCMIS Data Center Contractor Requirements

A.5.1.1.1 Operate under OIR State Data Center guidelines.

A.5.1.1.2 Maintain Bureau of TennCare 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 of TennCare.

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 must meet federal certification requirements defined in the most current version of Part 11 of the State Medicaid Manual. The Contractor must ensure that takeover of the TCMIS results in a complete, stable, and fully operational TCMIS at the start of Operations on January 1, 2009. Federal certification shall 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 Transition and Implementation will 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 must meet and maintain all certification requirements. The Contractor must ensure the TCMIS certification is continuous throughout the Transition and Takeover period, and maintained throughout the contract term, and any amendments to extend the 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 will 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 will 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 will 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 Submit and obtain approval of the final TCMIS systems documentation and TCMIS operational documentation;

A.5.2.2.2 Complete and install updated versions of all system material previously submitted or missing in the online library;

A.5.2.2.3 Participate in certification planning, and prepare review materials to demonstrate system compliance with certification criteria;

A.5.2.2.4 Assist the Bureau in developing presentation materials;

A.5.2.2.5 Provide copies of all system outputs needed to demonstrate full functionality back to the start of operations;

A.5.2.2.6 Participate, as necessary, during the federal on-site certification review;

A.5.2.2.7 Assist the Bureau in locating material needed to answer review team questions;

A.5.2.2.8 Provide any additional materials needed to resolve any post-review corrective actions;

A.5.2.2.9 Retain sufficient operations staff to provide post-implementation support during the initial months of operations through certification;

A.5.2.2.10 Monitor the performance of the TCMIS during the initial months of operations;

A.5.2.2.11 Modify the TCMIS, as needed, to resolve problems identified during the initial months of operations;

A.5.2.2.12 Resolve any and all corrective actions needed to finalize federal approval, with Bureau approval;

A.5.2.2.13 Meet with the Bureau on a regular basis to discuss post-implementation issues; and

A.5.2.2.14 Propose solutions to post-implementation issues to the Bureau.

A.5.2.3 MMIS Certification Bureau Responsibilities

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 will 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 part 6.1.2.2.3.3 of Attachment 2 of the 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 part 6.1.2.2.3.6.3 of Attachment 2 of the Contract.

A.5.3 Software License Maintenance

The Contractor must 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 will obtain and maintain the software licensure and any additional copies required as directed by the Bureau.

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 Transition and Implementation activities, and shall update and test this plan as agreed upon with the Bureau of TennCare. The plan must be in accordance with state standards as established by the Tennessee Emergency Management Agency (TEMA) for Continuity of Operations Plan documentation. The BCCP plan must establish adequate backup processes for all TCMIS systems and operational functions and address the potential impacts of disaster occurrence. Contingency plans are composed of two (2) fundamental operations - System Back-up and Disaster Recovery.

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 will 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 must provide for off-site storage of back-up operating instructions, procedures, reference files, systems documentation, programs, procedures, and operational files. Procedures must 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 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 All proposed off-site procedures, locations, and protocols shall be approved by

the Bureau in advance.

A.5.4.2.10 The Contractor must clearly document all of the components and file systems that would be required for a full restore.

A.5.4.2.11 The Contractor must 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 will 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 of TennCare 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 will continue to perform the test until satisfactory, at no additional cost.

A.5.4.2.17 The Contractor must 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 must be available and present at the Bureau site.

A.5.4.2.19 The BCCP must identify potential system failures for each core business process.

A.5.4.2.20 The BCCP must contain a risk analysis for each core business process.

A.5.4.2.21 The BCCP must contain an impact analysis for each core business process.

A.5.4.2.22 The BCCP must contain a definition of minimum acceptable levels of outputs for each core business process.

A.5.4.2.23 The BCCP must contain documentation of contingency plans.

A.5.4.2.24 The BCCP must contain definition of triggers for activating contingency plans.

A.5.4.2.25 The BCCP must contain discussion of establishment of a business resumption team.

A.5.4.2.26 The BCCP must address maintenance of updated disaster recovery plans and procedures.

A.5.4.2.27 The BCCP must 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 must 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 will be required to prepare and maintain a Disaster Recovery Plan as part of the BCCP and provide the Bureau with up-to-date copies at least once a year during the term of the Contract. The disaster recovery plan must be submitted to the Bureau for approval prior to the systems implementation and whenever changes are required.

A.5.4.2.30 The Contractor must ensure that each aspect of the Disaster Recovery Plan is detailed as to both Contractor and Bureau responsibilities and must satisfy all requirements for federal certification. Normal TCMIS day-to-day activities and services must be resumed within five (5) working days of the inoperable condition at the primary site(s).

A.5.4.2.31 The Contractor must dedicate two (2) 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 must address Checkpoint/restart capabilities.

A.5.4.2.34 The Disaster Recovery Plan must address retention and storage of backup files and software.

A.5.4.2.35 The Disaster Recovery Plan must address Hardware backup for the main processor(s).

A.5.4.2.36 The Disaster Recovery Plan must address network backup for voice and data telecommunications circuits.

A.5.4.2.37 The Disaster Recovery Plan must address Contractor provided voice and data telecommunications equipment.

A.5.4.2.38 The Disaster Recovery Plan must 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 must 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 can be accomplished.

A.5.4.2.40 The Disaster Recovery Plan must 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 must 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 must address the maintenance of current system documentation and source program libraries at an off-site location.

A.5.4.2.43 The Contractor must 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 must 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 of TennCare.

A.5.4.2.44 The Contractor must demonstrate the disaster recovery capability for all critical system components at a remote site once during the first year of the Contract period and no less often than every two (2) calendar years, in accordance with the 45CFR 95.621(f). The demonstration at the remote site will 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.5.4.2.44.4 Verification 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 assumption of FM operations.

A.5.4.3.2 Submit a Security Plan within thirty (30) calendar days of Contract signing, and update annually thereafter.

A.5.4.4 BCCP Bureau Responsibilities

A.5.4.4.1 The Bureau of TennCare will approve the Business Continuity and Contingency Plan.

A.5.4.4.2 The Bureau of TennCare will 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 Transition and Implementation, Operations, and Enhancement processes. The quality measurement process applies to plans and documents, as well as programs and operational functions. The Quality Management plan must 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 must identify and inform the Bureau of TennCare 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 will ensure a mechanism that eliminates the potential for problems with version control when testing software and will 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 will have an ongoing relationship with the Bureau of TennCare's staff that is based on trust, confidentiality, objectivity, and integrity. As TCMIS operations specialists, the Facilities Manager will 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 is 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 the 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, transition 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 life of the 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. Use of subcontractors will have been clearly explained in the Proposal, and any subcontractor will have been identified by name. 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 the 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; its willingness to perform such work; and certification that it 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 will perform an essential role in the Bureau of TennCare 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 will have been developed as part of the Proposal and refined early to address the needs and specific opportunities for quality improvement throughout the Contract period.

A.5.6.2.1 The QA/QI plan should 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 Transition, Operations, and Enhancement Phases.

A.5.6.3 Functional Area Contractor Requirements

A.5.6.3.1 Compliance with Federal Standards

The system must meet all federal requirements for certification as prescribed in the State Medicaid Manual, Part 11, as well as 42 and 45 CFR. In addition, the Contractor must 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 must 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. The Contractor must also handle the transition of other future requirements of HIPAA which may impact system and policy operations for the Bureau of TennCare. The Contractor must maintain and operate TCMIS in full compliance with HIPAA. The Contractor is 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 must 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 must 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 must 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).

The Contractor must 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 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 signing. 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 must 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 must be supported and remain current. In addition, all risk vulnerabilities identified must be reported to the Bureau. Vulnerabilities must be patched immediately upon approval of the Bureau. All workstations and Servers that access the systems must also have antivirus software installed, and this software must remain current. The Contractor must configure and maintain a firewall to restrict access to systems from all unauthorized users. Access to the systems must be controlled and restricted to only those with a need to access that system. Software used must be continually supported by the software vendor. The Contractor must 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 the 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 must be conducted annually, and new employees must be trained within sixty (60) days of hire.

Publicly available information should 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 must 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 must verify with the Bureau that such information may be disclosed.

A.5.6.3.2.3 Auditing

The Contractor must ensure that the TCMIS facilitates auditing of individual transactions. Automated audit trails must 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.

Audits may be performed by a number of State and Federal Agencies, including, but not limited to, the Bureau of TennCare, the Centers for Medicare and Medicaid Services and the Office of the Comptroller of the Treasury.

An independent auditor must perform SAS-70 audits annually at the Facilities Manager Operations sites. Findings and action plans must be submitted to the Bureau. No additional funding will be allocated to perform the audit tasks, therefore; these audits should be included in the price of the Contract. The Contractor and all subcontractors must 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 must 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 must 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 control, 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.

A.5.6.3.2.3.1. The Contractor shall provide 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 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 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 statute, 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 period. The Contractor must provide management, supervisory and technical staff availability by email for ease of communication with the Bureau. The project coordinator and/or designated staff will also participate in weekly status meetings in person or by telephone conference call and will 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 2) contain specific system and operational performance requirements the Contractor must adhere to for the duration of the Contract. Failure to comply with these requirements can result in damages. System and operational performance requirements are provided in the 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 of TennCare's transactions are conducted electronically, thus the electronic data transmission and translation function is a central component of TCMIS functionality. It must provide reliability and capacity for volume, peak loads, and quick processing speeds.

The Contractor's translation approach should 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

A.5.6.6.4 Health Care Claims Status Request (276)

A.5.6.6.5 Health Care Claims Status Response (277)

A.5.6.6.6 Health Care Services Review – Request for Review and Response (278)

A.5.6.6.7 Health Care Services Review – Notification and Acknowledgement (Unsolicited 278)

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 will 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 via 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, will never be purged, or will be purged on a different schedule; for example, 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, will be archived according to Bureau standards.

A.5.6.8.4 Data retention for Protected Health Information must 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 must 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 must 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 must 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 includes Reporting, such as federal and State reporting, Production and Distribution reporting and other reports, as requested by the Bureau. The outputs must meet all federal and State reporting requirements and performance standards in Part 11 of the State Medicaid Manual, and will provide the information necessary to assess compliance with federal certification and audit review standards. The outputs will 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 start date of this Contract, 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 will 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, must be maintained by the Contractor

A.5.7.3 Reporting Contractor Requirements

A.5.7.3.1 Provide management reporting to the Bureau of TennCare for all aspects of the TCMIS. Assist the Bureau of TennCare 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 of TennCare to meet all federal data set requirements for federal reporting.

A.5.7.3.3 Produce ad hoc reports as requested by the Bureau of TennCare.

A.5.7.3.4 Produce and assist the Bureau of TennCare in definition and design of general system performance reports.

A.5.7.3.5 The TCMIS must provide the ability for all output data, including reports, to be produced in PDF format for online viewing and printing. Where possible, the TCMIS must utilize functionality already provided by the State infrastructure, such as Filenet and COLD for output reports.

A.5.7.3.6 The TCMIS must 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 must provide for the creation and update of a report scheduling utility. Wherever possible, the TCMIS must utilize functionality already provided by the State infrastructure.

A.5.7.3.8 The TCMIS must 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 must 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 must 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 must 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 must provide for the “on demand” printing of documents and correspondence. In addition, the TCMIS must 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 must 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 the 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 which 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 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 Track and report on services provided specifically to foster care enrollees, as directed by the Bureau.

A.5.7.3.56 Generate Medicaid Eligibility Quality Control (MEQC) reports according to CMS time frames if required by the Bureau.

A.5.7.3.57 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.5.7.3.58 Ensure no disruption to federal reporting activities.

A.5.7.3.59 Generate any outputs necessary to meet federal reporting requirements.

A.5.7.3.60 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.5.7.3.61 Maintain all financial and other program-related information necessary for reporting;

A.5.7.3.62 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.5.7.3.63 Meet the federal reporting requirements and performance standards in Part 11 of the State Medicaid Manual.

A.5.7.3.64 Generate federal reports in accordance with federally required timeframes and media.

A.5.8 TCMIS Infrastructure Documentation

The Contractor is 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 TCMIS Documentation Contractor Requirements

A.5.8.1.1 Any TCMIS documentation updates must be provided within thirty (30) business days prior to the assumption of FM operations.

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 is 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 Contactor's assumption of FM operations.

A.5.8.1.4 Additional 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 all copies of the TCMIS infrastructure documentation are 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 must 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 must 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 will 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 of TennCare's copies as subsequent updates require.

A.5.8.1.14 The TCMIS documentation must be accessible online, using the Contractor's Documentation software. Specific requirements pertaining to this feature are found in Enhancement #5, Section A.2.14.

A.5.8.1.15 The Contractor must 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 must 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 must 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 must 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 should correspond to nomenclature used in subsystem documentation.

A.5.8.2.7.10 All subsystem documentation must be referenced, and must 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 MCO 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 should 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 should describe training strategies including methods, materials, audience, and timing.

A.5.8.2.11.3 Training plans should be submitted to Bureau staff in sufficient time to allow for approval one 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 must 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.2.14, Enhancement #5.

A.5.9.1.2 The Contractor is responsible for demonstrating that all operational software and related materials, as well as all proprietary products used in TCMIS operations, are working as expected within thirty (30) business days prior to the assumption of facilities management operations, (January 1, 2009).

A.5.9.1.3 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 must be complete and presented to the Bureau within thirty (30) days prior to the Contractor’s assumption of facilities management operations.

A.5.9.1.4 The Contractor shall be responsible for the production and distribution of all updated copies (hard and soft), of the TCMIS infrastructure documentation to ensure that they are current, and shall be responsible for maintaining and updating each of the Bureau’s copies.

A.5.9.1.5 Hardcopies of documentation must use 8 ½” x 11” pages in three (3) ring binder form, with pages numbered within each section, and a revision date on each page. Revisions must be clearly identified and contain revision summary pages.

A.5.9.1.6 The Contractor shall maintain the online version of the documentation, updating each component as ongoing updates to the TCMIS require.

A.5.9.1.7 The Contractor shall deliver all materials and information needed for Certification review.

A.6 Staffing

A.6.1 Facilities Manager Staffing Contractor Requirements

The Contractor shall be required to provide and maintain a staff, beginning December 1, 2008, sufficient to complete all task functions required for the operation of the TCMIS throughout the life of this Contract. All personnel shall be the employees of the Contractor and shall be fully qualified to perform the work required in the Contract. The Contractor must 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 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.

The Contractor shall notify the Bureau, in writing, of any change in key personnel at least thirty (30) days prior to the change. The Contractor shall, upon request, provide the Bureau with a resume of any member of its staff or subcontractor's staff assigned to any aspect of the performance of this Contract.

The Contractor shall provide resumes for all key personnel, and other personnel if requested by the Bureau. Key operations personnel are defined as:

a. Account Manager

b. Project Management Office (PMO) Director

c. Operations Project Manger(s)

d. Operations Processing Manager

e. Computer Operations Manager

f. TCMIS Systems Manager

g. Database Administrator

h. Enhancement Project Manager

i. Transition Project Manager

j. Transition Deputy Project Manager

A.6.2 Systems Staffing Contractor Requirements

The Contractor must provide staffing to meet the requirements and performance measures defined within the Contract. Additionally, the Contractor must provide, at a minimum, the staffing levels stated in this section for Modification and Enhancement staff, and Maintenance and User Support staff.

A full-time key position of the TCMIS System Manager is required on-site to manage the staff and activities involved in supporting future system modifications and enhancements. Staff responsible for modifications and enhancements shall be distinct from Maintenance and User support staff.

A.6.2.1 Modification and Enhancement Staff Contractor Requirements

The Contractor shall be required to provide and maintain modification and enhancement staff to perform the system modifications and enhancements of the TCMIS. The

Contractor's modification and enhancement staff may also perform maintenance and user support functions with approval from the Bureau.

The Contractor shall assign all other resources to subsystems or functional areas as necessary to perform all system modifications and enhancements of the TCMIS. The Contractor must ensure that all staff members possess the necessary technical background, education, and skills to perform in the various environments necessary to support the TCMIS.

Staff to be included within the Modification and Enhancement Staff shall be as follows:

- Project Managers
- Information Analysts/Specialists
- Business Services Analysts
- Technical Delivery Team Managers (TDTM)
- Project Analysts
- Work Planner
- Release Coordinator
- Change Management Coordinator
- General Support Clerk

The Contractor shall provide a monthly report of time spent by job category for Project Managers, Information Analysts, and Business Services Analysts. This time includes all time with the exception of Holidays, Vacations, and Sick time. Based upon the Contractor's staffing levels the minimum number hours are:

Information Analysts/Specialists	93,810 hours per year
Business Services Analysts:	26,550 hours per year
Project Managers:	10,620 hours per year

Technical Delivery Team Managers (TDTM) and the rest of the Project Management Office (PMO) time, including the Project Analysts, Work Planner, Release Coordinator, Change Management Coordinator, and General Support Clerk, will not be applied to the minimum hours above. At the end of each State fiscal year, the Contractor shall provide an accounting of the hours spent by job category during that fiscal year. If the total of a job category falls below the minimum, or the Contractor falls below the threshold staffing levels, the State may impose liquidated damages. Refer to part 6.1.2.2.2.14, 6.1.2.2.2.15, and 6.2.2.2.16 of the Contract.

Any modification or enhancement that requires services outside of the existing staff shall be considered a Special Project and will be funded and managed separately from the existing staffing and the existing processes. For information relating to Special Projects, refer to paragraph section A.6.5.

A.6.2.2 Maintenance and User Support Staff

The Maintenance and User Support Staff should include, but not be limited to, the job categories, quantity of staff, and percentages of onsite, offsite, dedicated, and shared resources as defined in the following table. The Contractor must ensure that the Bureau will receive a minimum of 1,770 hours per person per year in these categories. This time includes all time with the exception of Holidays, Vacations, and Sick time.

If the total of a job category falls below the minimum, or the Contractor falls below the threshold staffing levels, the State may impose liquidated damages. Refer to part

6.1.2.2.2.17 of the Contract. See also parts 6.1.2.2.2.18 and 6.1.2.2.2.19 for liquidated damage assessments for on-site and dedicated staffing requirements.

Maintenance and User Support Staff Table

CATEGORY	# of Staff	Onsite %	Offsite %	Dedicated %	Shared Resource %
Information Specialist - Senior	31	75%	25%	95%	5%
Information Specialist	7	75%	25%	95%	5%
Information Analyst	23	75%	25%	95%	5%
Information Associate	8	75%	25%	95%	5%
Business Services Analyst - Senior	4	100%	0%	100%	0%
Business Services Analyst – Advanced	8	100%	0%	100%	0%
Business Services Analyst	12	100%	0%	100%	0%
Technical Delivery Team Manager	4	100%	0%	100%	0%
Project Manager	5	100%	0%	100%	0%
Project Analyst - Senior	5	100%	0%	100%	0%
Project Analyst - Advanced	5	100%	0%	100%	0%
Project Analyst	5	100%	0%	100%	0%
Data Base Administrator	3	75%	25%	95%	5%
Data Base Associate	5	100%	0%	100%	0%
Infrastructure Specialist Senior	3	75%	25%	95%	5%
Systems Administrator - Advanced	2	100%	0%	100%	0%
Systems Administrator	2	100%	0%	100%	0%
Systems Administrator - Associate	2	100%	0%	100%	0%
Computer Operator	2	100%	0%	100%	0%
QA Specialist - Advanced	5	100%	0%	100%	0%
QA Specialist	5	100%	0%	100%	0%
Documentation Project Manager	1	100%	0%	100%	0%
Technical Writer	5	100%	0%	100%	0%
Specialized Support Clerk	5	100%	0%	100%	0%
General Support Clerk	3	100%	0%	100%	0%
Change Management Coordinator	1	100%	0%	100%	0%
Release Coordinator	1	100%	0%	100%	0%
Work Planner	1	100%	0%	100%	0%

A.6.3 Roles and Responsibilities

The Contractor must have qualified staff available to support all TCMIS functions. Although roles and responsibilities are documented in this section, the responsibilities listed should not be considered all-inclusive.

A.6.3.1 Account Manager

The Account Manager directs and coordinates overall activities and is responsible for the complete TCMIS account including the administration of ongoing support and management of transition activities, and Enhancement implementations. This individual will be responsible for managing all facets of the Facilities Management Contract, which will 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.6.3.1.1 Deputy Account Manager

The Deputy Account Manager works directly with the Account Manager to assist in overseeing all tasks associated with managing the TCMIS account.

A.6.3.2 Project Management Office (PMO) Director

The Project Manager Office Director will 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.6.3.3 Operations Project Manager(s)

a. Plan, direct and manage the TCMIS operation, including interrelated projects such as transitional Takeover activities and enhancement implementations. The Operations Project Manager(s) will also work with the Transition Project Manager and Enhancement Project Manager for coordination of these overlapping activities as projects become implemented.

b. Facilitate status review meetings among project team members and Bureau staff.

c. Plan, schedule, monitor, and report on Operations activities.

d. Provide written status reports as required.

e. Ensure timely development and delivery of quality project deliverables.

A.6.3.4 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.6.3.5 Computer Operations Manager

The Computer Operations Manager will 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.6.3.6 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.6.3.7 Enhancement Project Manager

The Enhancement Project Manager will 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 will 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.6.3.8 Transition Project Manager

The Transition Project Manager will manage, direct, and coordinate overall associated transition activities to ensure that the baseline system is complete, fully functional, and in accordance with the federal requirements for MMIS certification. Other Responsibilities include:

a. Acquire personnel resources required to perform transition and takeover functions.

b. Develop a Work Plan, detailing activities and timelines associated with each.

c. Attend Bureau meetings as required.

d. Assure that all transition activities are performed according to the Work Plan.

e. Coordinate priorities and scheduling with Bureau staff.

f. Monitor all project dates.

g. Work to ensure a smooth execution of the Takeover.

A.6.3.9 Transition Deputy Project Manager

The Transition Deputy Project Manager will assist the Transition Project Manager. This manager will work with other Contractor resources and Bureau staff to support the Takeover of the TCMIS iC infrastructure. The responsibilities include the following:

a. Conduct status meetings weekly, or more often, if necessary.

b. Address project team deficiencies and articulate resolutions.

c. Work to uphold critical project dates.

d. Communicate problems to project leadership.

A.6.3.10 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.6.3.11 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.6.3.12 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.6.3.13 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.6.3.14 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.6.3.15 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.6.3.16 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.6.3.17 Database Associate

The Database Associate will 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.6.3.18 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.6.3.19 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.6.3.20 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, parm dates, and control numbers).

A.6.3.21 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.6.3.22 Documentation Project Manager

a. Coordinate tasks associated with composing TCMIS Systems, operations, training, procedures and user documentation.

b. Assign tasks to technical writers.

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.6.3.23 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.6.3.24 Specialized Support Clerk

a. Use subject-matter knowledge and judgment to resolve data maintenance issues.

b. Perform file maintenance functions for data resolution including eligibility, enrollment, claims, TPL, premiums, Medicare Buy-In, LTC and as required by the Bureau.

c. Monitor and resolve keying or data entry errors.

d. Perform claims suspense resolution activities by following approved procedures for resolving edits to adjudicate claims.

e. Support resolution of erroneous scanned document matters.

f. 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.

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 Business Process Staffing

The Contractor must provide staffing to meet the requirements and performance measures defined within the Contract. Additionally, the Contractor must provide, at a minimum, the staffing levels stated below for Mailroom, Customer Service, Production Server Support, Non-Production Server Support, Suspense Processing, Third Party Liability and Other business process staffing as needed to perform duties as required or to support the Contract.

A.6.4.1 Mailroom Staff

The Mailroom must be staffed with at least eleven (11) full time equivalents (FTEs) plus a Supervisor.

Mailroom Staff Category	Number of Staff
Mailroom Staff	11 FTE
Mailroom Supervisor	1

A.6.4.1.1 Mailroom Staff Responsibilities

Responsibilities performed by mailroom staff include the following:

a. Receiving, sorting, screening and distributing mail;

b. Batching, Indexing, Imaging and enumerating documents;

c. Facilitating Claims record management; and

d. Performing Courier duties for collecting and delivering various materials and documents to and from multiple destinations.

Additional information for current Mailroom Operations can be found in the PWB in the Project Management Documentation section under Mailroom Operations

A.6.4.2 Customer Service for Providers

The Contractor shall be required to provide staff to perform customer service functions for provider relations. 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.

A.6.4.2.1 Provider Customer Service Staff

Within the Customer Service/Provider Relations Department, the Contractor would employ the following personnel:

Provider Customer Service Category	Number of Staff
Customer Service/Provider Relations Team Leader	1
Adjudication and Training Coordinator	1
Customer service representatives (CSR)	3

The Provider Customer 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 will be completed within a certain timeframe, or the Contractor is awaiting direction from the Bureau on which action is necessary.

A.6.4.2.2 Provider Customer Service Minimum Responsibilities

The Contractor shall perform the following Provider Customer Service activities:

Develop procedures for escalation of customer service issues.

Establish appropriate Bureau review, approval and sign-off of escalation procedures.

Establish preliminary production standards for response which will be adjusted as experience is gained and standards are validated.

Identify and hire staff based on ongoing call level projections – one (1) customer service representation for every forty (40) calls per week.

Develop training for the CSR staff to include escalation points for each level.

Establish facility and infrastructure requirements to accommodate a customer service/provider relations unit.

Develop reporting of call escalation and resolution metrics for monthly status reporting to the Bureau.

Assist the Bureau with development of a provider manual.

Develop training materials for providers for submission of crossover claims.

Ensure that calls are responded to and resolved within timeframes established between the Contractor and the Bureau.

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.

Identify and communicate systemic problems to the Contractor's management and the Bureau and assist with resolution.

Participate in change management activities to ensure procedures and processes are updated when system or policy changes are implemented.

Provide regular reporting of status to Bureau business unit.

A.6.4.3 Production Server Support

A.6.4.3.1 The Contractor will provide two (2) full time equivalents (FTEs) to support the Production Windows Servers located outside of the OIR data center. This includes the RRI Servers located at 310 Great Circle Road, and the NICE Server at the Tennessee Prison for Women. In addition, this includes support for the Kodak Scan stations at 310 Great Circle Road, except for the PC hardware and PC OS.

Category	Number of Staff
Production Server Support Staff	2 FTEs

A.6.4.4 Non-Production Server Support

A.6.4.4.1 The Contractor shall provide three point two (3.2) full time equivalents (FTEs) to support the Non-Production TCMIS environments for Development, Training and Test/UAT Servers located outside of the OIR data center. This includes all the Sun and Dell Servers located at 310 Great Circle Road.

Category	Number of Staff
Non-Production Server Support Staff	3.2 FTEs

A.6.4.5 Suspense Processing Support Staff

The minimum number of Suspense Processing Support staff is depicted on the following table:

Category	Number of Staff
Suspense Processing Claims Manager	1
Suspense Processing Specialized Support Clerks	5

The Contractor shall provide one (1) full-time Claims Manager to support processing of all proposed suspense processing.

The Contractor shall provide five (5) full-time Specialized Support Clerks to perform the suspense resolution activities.

A.6.4.5.1 Suspense Processing Responsibilities

Suspense resolution activities include the following:

- Accessing the pending claims file,
- Selecting the pending claim to be resolved,
- Reviewing all claim images associated with the pending claim to check for keying errors,
- Following the approved procedures for resolving the edits set on the claim record until the claim is in an adjudicated status.

A.6.4.5.2 Suspense Processing Volume

The Suspense Processing staff shall support the resolution of at least eight thousand, one hundred (8,100) claims per week. However, the Contractor should 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 will 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 must provide sufficient supporting documentation to obtain Bureau approval for reimbursement of the excess transaction costs.

A.6.4.6 Third Party Liability Processing

A.6.4.6.1 The Contractor shall provide adequate staffing for the TPL functions as depicted in the table below.

Category	Number of Staff
TPL Team Leader	1
TPL Mail and Imaging Staff	2 FTEs
TPL Data Entry Staff	6.5 FTEs
TPL Insurance Co. Contacts	2 FTEs

A.6.4.6.2 Third Party Liability Staffing Responsibilities

The full-time TPL Team Leader will be responsible for providing direction, coordinating, and monitoring the TPL functions to ensure that contract requirements are met.

The TPL Mail and Imaging staff will be responsible for facilitating the receipt of the TPL questionnaires from the mail, scan them and index the image to a recipient.

The TPL Data Entry staff will perform manual updates relating to the returned questionnaires.

The TPL Insurance company contact analysts will perform duties associated with communicating with insurance companies to facilitate TPL collections.

A.6.4.7 Other Business Staff:

A.6.4.7.1 Administrative Assistants

The Administrative Assistants will support the Contractor's Account management staff and performs associated functions including record tracking, report preparation, meeting coordination, and organizing documents and correspondence.

A.6.4.7.2 Training Developer/Coordinator

The Training Coordinator is responsible for providing training curriculum and materials on the use, processes and functions, and the navigation features of the TCMIS infrastructure. The training will 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.

e. Document feedback from participants and develop improvement strategy.

f. Document and report inaccuracies and inconsistencies to Q/A staff.

g. Produce weekly 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.

A.6.5 Special Projects

A.6.5.1 Special Project Staffing

Whenever staffing is needed for special projects, a separate payment arrangement will be made between the Contractor and the Bureau for staffing. This compensation method is described in Section C.3. and C.3.4.

A.6.5.2 Special Project Determination

There will 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 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.

The Change Control Board (CCB) will be the avenue to designate a project as a Special Project. Once a project is designated as special, the Contractor will work 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 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 be considered a Special Project, and

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

A.6.5.3 Known Special Projects

Several known forthcoming projects are included in RFP Attachment 6.10.1: Current and Future Initiatives. The State and federally mandated initiatives will require changes to the TCMIS and Business Process Management services. The contractor must be aware of these upcoming initiatives and be prepared to address these future needs.

B. CONTRACT PERIOD:

B.1 Contract Term. This Contract shall be effective for the period commencing on 01/11/2008 and ending on 12/31/2012. The State shall have no obligation for services rendered by the Contractor which are not performed within the specified period.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability: In no event shall the maximum liability of the State under this Contract exceed WRITTEN DOLLAR AMOUNT ($NUMBER AMOUNT). 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 this 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 this 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, (e.g. postage, expenses related to special mailings), shall include substantiating documentation and the pre-approval by the State.

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.

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. Transition and Implementation 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).

Transition and Implementation Pricing Detail Table follows:

ITEM #	LINE ITEM DESCRIPTION	FIXED PRICE
1	**Assessment 1 – Web Assessment Section A.2.2.1.1**	$
2	**Assessment 2 – Change Management Assessment Section A.2.2.1.2**	$
3	**Assessment 3 – Version Control / Source Code Control Assessment Section A.2.2.1.3**	$
4	**Assessment 4 – MITA Assessment Section A.2.2.1.4**	$
5	**Assessment 5 – Recipient and Provider Linking Assessment Section A.2.2.1.5**	$
6	**Assessment 6 – MAR Review Section A.2.2.1.6**	$
7	**Assessment 7 – SUR Review Section A.2.2.1.7**	$
8	**Assessment 8 – Mailroom Business Process Assessment Section A.2.2.1.8**	$
9	**Assessment 9 – TCMIS Performance Assessment Section A.2.2.1.9**	$
10	**Assessment 10 – State Software Licenses Assessment Section A.2.2.1.10**	$
11	**Assessment 11 – Work Flow Management Assessment Section A.2.2.1.11**	$
12	**Assessment 12 – Operations Functionality Section A.2.2.1.12**	$
13	**Assessment 13 Oracle Financials Section A.2.2.1.13**	$

The Bureau will reimburse the Contractor for actual costs for any transition related infrastructure costs which will no longer be incurred during the operating phase of the contract (including office space and related costs, hardware, software licenses, etc) required for any Non-Assessment transition tasks or Non-Enhancement tasks up to fifteen percent (15%) of the annual average fixed cost of the Operations Base Rate, (Refer to C.3.3 Pricing Schedule C1 – Operations Costs – Base Rate). Invoices and supporting documentation for these transition payments can be submitted to the Bureau the later of January 1, 2009, or the start of operations (e.g. successful completion of the TCMIS takeover by the Contractor) and must contain sufficient supporting detail to obtain Bureau approval for reimbursement of actual additional costs.

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	Enhancement #1 CMMI Level 2 Appraisal (Contract Section A.2.10)	
	Total Enhancement #1	$
E1.1	Enhancement #1 cont. CMMI Level 3 Appraisal (Contract Section A.2.10)	
	Total Enhancement #1.1	$
E2	Implement the ClaimCheck (Contract Section A.2.11)	
	Total Enhancement #2	$
E3	Implement PMO (Contract Section A.2.12)	
	Total Enhancement #3	$
E4	Implement a COTS Dashboard (Contract Section A.2.13)	
	Total Enhancement #4	$
E5	Develop or provide a COTS Documentation software (Contract Section A.2.14)	
	Total Enhancement #5	$
E6	Implement Enhanced Test Environment (Contract Section A.2.15)	
	Total Enhancement #6	$
E7	Conduct Detailed Documentation of all TennCare business processes (Contract Section A.2.16	
	Total Enhancement #7	$

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 Re-procurement 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 of TennCare 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). 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 should 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 (1/1/2009 – 12/31/2009)	Operational Year 2 (1/1/2010 – 12/31/2010)	Operational Year 3 (1/1/2011 – 12/31/2011)	Operational Year 4 (1/1/2012 – 12/31/2012)	Average
1	Base Rate	$	$	$	$	$

Pricing Schedule C2

Operations Costs – Incentive Rate (TCMIS)

		Fixed Cost				
Item #	Line Item Description	Operational Year 1 (1/1/2009 – 12/31/2009)	Operational Year 2 (1/1/2010 – 12/31/2010)	Operational Year 3 (1/1/2011 – 12/31/2011)	Operational Year 4 (1/1/2012 – 12/31/2012)	Average
1	Incentive Rate	$	$	$	$	$

Pricing Schedule C3

Operations Costs – Enhancement Operations (TCMIS)

		Fixed Cost			
Item #	Line Item Description	Operational Year 1 (1/1/2009 – 12/31/2009)	Operational Year 2 (1/1/2010 – 12/31/2010)	Operational Year 3 (1/1/2011 – 12/31/2011)	Operational Year 4 (1/1/2012 – 12/31/2012)
E1	Operations costs associated with maintaining CMMI Level 2 Appraisal	$	$	$	$
E1.1	Operations costs associated with maintaining CMMI Level 3 Appraisal	$	$	$	$
E2	Operations costs associated with ClaimCheck	$	$	$	$
E3	Operations costs associated with PMO	$	$	$	$
E4	Operations costs associated with the COTS Dashboard	$	$	$	$
E5	Operations costs associated with the COTS Documentation software	$	$	$	$
E6	Operations costs associated with the Enhanced Test Environment	$	$	$	$
E7	Operations costs associated with maintaining the TennCare process documentation, including system and change and process model integration	$	$	$	$

C.3.4. Excess Staffing

Excess Staffing or 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**	**HOURLY RATE**
	1/11/2008 — 12/31/2008	01/01/2009 — 12/31/2009	01/01/2010 — 12/31/2010	01/01/2011 — 12/31/2011	01/01/2012 — 12/31/2012
Information Specialist - Senior	$	$	$	$	$
Information Specialist	$	$	$	$	$
Information Analyst	$	$	$	$	$
Information Associate	$	$	$	$	$
Business Services Analyst - Senior	$	$	$	$	$
Business Services Analyst - Advanced	$	$	$	$	$
Business Services Analyst	$	$	$	$	$
Technical Delivery Team Manager	$	$	$	$	$

CATEGORY	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE
	1/11/2008 — 12/31/2008	01/01/2009 — 12/31/2009	01/01/2010 — 12/31/2010	01/01/2011 — 12/31/2011	01/01/2012 — 12/31/2012
Project Manager	$	$	$	$	$
Project Analyst - Senior	$	$	$	$	$
Project Analyst - Advanced	$	$	$	$	$
Project Analyst	$	$	$	$	$
Data Base Administrator	$	$	$	$	$
Data Base Associate	$	$	$	$	$
Infrastructure Specialist Senior	$	$	$	$	$
Systems Administrator - -Advanced	$	$	$	$	$
Systems Administrator	$	$	$	$	$
Systems Administrator - Associate	$	$	$	$	$
Computer Operator	$	$	$	$	$
QA Specialist - Advanced	$	$	$	$	$
QA Specialist	$	$	$	$	$
Documentation Project Manager	$	$	$	$	$

CATEGORY	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE
	1/11/2008 — 12/31/2008	01/01/2009 — 12/31/2009	01/01/2010 — 12/31/2010	01/01/2011 — 12/31/2011	01/01/2012 — 12/31/2012
Technical Writer	$	$	$	$	$
Specialized Support Clerk	$	$	$	$	$
General Support Clerk	$	$	$	$	$
Change Management Coordinator	$	$	$	$	$
Release Coordinator	$	$	$	$	$
Work Planner	$	$	$	$	$

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 (invoices for excess ballots shall be submitted annually), 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			
	01/01/2009 12/31/2009	01/01/2010 – 12/31/2010	01/01/2011 – 12/31/2011	01/01/2012 – 12/31/2012
Suspense Transactions	$	$	$	$
Letters	$	$	$	$
Ballots	$	$	$	$

Note:

Excess Suspense Transactions is defined as suspended claims needing resolution activities. Excess suspense transactions will 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 must provide sufficient supporting documentation to obtain Bureau approval for reimbursement of the excess transaction costs.

Excess Letters is defined as those that are generated for special mailings. Excess Letters will be determined when the number of letters for special mailings exceeds four hundred thousand (400,000), annually. If the number of letters exceeds this total, then the Contractor shall be eligible for reimbursement of excess operations and/or excess staffing that will be needed to facilitate the special mailing processing. The Contractor must provide sufficient supporting documentation to obtain Bureau approval for reimbursement of the excess letters costs.

Excess Ballots is defined as those that are generated and mailed more than annually.

Excess Ballots will be determined when the number of ballots exceeds an annual total of one million, five hundred thousand (1,500,000). If the number of ballots exceeds this total in a twelve-month period, then the Contractor shall be eligible for reimbursement of excess operations and/or excess staffing that will be needed to facilitate the ballot processing. The Contractor must provide sufficient supporting documentation to obtain Bureau approval for reimbursement of the excess ballot 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 sales tax or shipping charges.

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 pertaining to "Conflicts of Interest" and "Nondiscrimination" (sections D.6. and D.7.). 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 1, 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 against the State 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 (1) 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 (1) 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, acts of God, natural disasters, riots, wars, strikes, 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.
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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

The Contractor:
NAME AND TITLE OF CONTRACTOR CONTACT PERSON
CONTRACTOR NAME
ADDRESS
TELEPHONE NUMBER
FACSIMILE NUMBER

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. 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 part 6.1.2.2 of Attachment 2 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 no event shall any Breach on the part of the State excuse the Contractor from full performance under this Contract. 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.6. 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.7. Annual Report and Audit: The Contractor shall prepare and submit, within nine (9) months after the close of the reporting period, an annual report of its activities funded under this Contract to the commissioner or head of the contracting agency, the Tennessee Comptroller of the Treasury, and the Commissioner of Finance and Administration. The annual report for any Contractor that receives five hundred thousand dollars ($500,000) or more in aggregate federal and State funding for all its programs shall include audited financial statements. All books of account and financial records shall be subject to annual audit by the Tennessee Comptroller of the Treasury or the Comptroller's duly appointed representative. When an audit is required, the Contractor may, with the prior approval of the Comptroller, engage a licensed independent public accountant to perform the audit. The audit contract between the Contractor and the licensed independent public accountant shall be on a contract form prescribed by the Tennessee Comptroller of the Treasury. Any such audit shall be performed in accordance with generally accepted government auditing standards, the provisions of OMB Circular A-133, if applicable, and the *Audit Manual for Governmental Units and Recipients of Grant Funds* published by the Tennessee Comptroller of the Treasury. The Contractor shall be responsible for reimbursement of the cost of the audit prepared by the Tennessee Comptroller of the Treasury, and payment of fees for the audit prepared by the licensed independent public accountant. Payment of the audit fees of the licensed independent public accountant by the Contractor shall be subject to the provisions relating to such fees contained in the prescribed contract form noted above. Copies of such audits shall be provided to the designated cognizant State agency, the State Contracting Department, the Tennessee Comptroller of the Treasury, and the Department of Finance and Administration and shall be made available to the public.

E.8. 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. The State grants to the Contractor a perpetual, worldwide, fully paid up right and license to copy, prepare derivative works based on, deliver, publish, perform, display, modify, improve, use, sell and sublicense any Work Product provided under this Contract. Further, the Contractor retains the right to use the general ideas, concepts and know-how of Contractor developed during performance of this Contract, without obligation of notice or accounting to the State. This Contract shall not preclude Contractor from (1) independently developing materials outside this Contract that are competitive, irrespective of their similarity to materials which might be delivered to the State hereunder; or (2) providing consulting or other services of any kind or nature whatsoever to any individual or entity as Contractor in its sole discretion deems appropriate.

E.9. 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, 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 initial 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.10. 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.11. 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.12. 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.13. 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.14. Incorporation of Additional Documents: Included in this Contract by reference are the following documents:

a. The Contract document and its attachments
b. All Clarifications and addenda made to the Contractor's Proposal
c. The Request for Proposal and its associated amendments
d. Technical Specifications provided to the Contractor
e. The Contractor's Proposal
f. The HIPAA Business Associate Agreement.

In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this Contract, these documents shall govern in order of precedence detailed above.

E.15. Work-papers Subject to Review: The Contractor shall make all audit, accounting, or financial analysis work-papers, notes, and other documentation available for review by the Comptroller of the Treasury or his representatives, upon request, during normal working hours either while the analysis is in progress or subsequent to the completion of this Contract.

E.16. 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.17. Public Funding Notice: All notices, informational pamphlets, press releases, research reports, signs, and similar public notices prepared and released by the Contractor relative to this Contract shall include the statement, "This project is funded under an agreement with the State of Tennessee." Any such notices by the Contractor shall be approved by the State.

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. 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.21. 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.22. 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.23. 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.24. 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 for 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.25. 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 3. 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.26. Contractor Commitment to Diversity: The Contractor shall comply with and make reasonable business efforts to exceed the commitment to diversity represented by the Contractor's proposal responding to RFP 318.65-211 (Attachment 6.3, Section B, Item B.13.) and resulting in this Contract.

The Contractor shall assist the State in monitoring the Contractor's performance of this commitment by providing, as requested, a 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.

IN WITNESS WHEREOF:	
CONTRACTOR LEGAL ENTITY NAME:	
CONTRACTOR SIGNATURE	**Date**
PRINTED NAME AND TITLE OF AUTHORIZED CONTRACTOR SIGNATORY (above)	
DEPT. OF FINANCE AND ADMINISTRATION, BUREAU OF TENNCARE:	
M. D. Goetz, Jr., Commissioner	**Date**
APPROVED:	
DEPARTMENT OF FINANCE AND ADMINISTRATION:	
M.D. Goetz, Jr., Commissioner	**Date**
COMPTROLLER OF THE TREASURY:	
John G. Morgan, Comptroller of the Treasury	**Date**

FA CONTRACT INFORMATION SUPPLEMENT FOR ALL FA-TYPE CONTRACTS — COMPLETE EITHER SECTION A OR SECTION B			
Contract RFS #			
Contractor:			
SECTION A— CONTRACTOR IS AN INDIVIDUAL		**SECTION B— CONTRACTOR IS A COMPANY** (*e.g.*, sole proprietorship, partnership, or corporation)	
Is or has the contractor been a state employee?		**Does an individual, who is or has been a state employee, own controlling interest in (or own) the contractor company?**	
☐	**NO** (no additional information required)	☐	**NO** (no additional information required)
☐	**YES**	☐	**YES**
Was such employment within the past six months?		**Was such employment within the past six months?**	
☐	**NO**	☐	**NO**
☐	**YES** *(an approved rule exception permitting a contract within six months of employment is also required)*	☐	**YES** *(an approved rule exception permitting a contract within six months of employment is also required)*
Does the contractor receive Tennessee Consolidated Retirement System (TCRS) retirement benefits?		**Does the individual who owns controlling interest in the contractor company receive Tennessee Consolidated Retirement System (TCRS) retirement benefits?**	
☐	**NO**	☐	**NO**
☐	**YES** (the procuring agency general counsel MUST sign an analysis of this procurement using the TCRS analysis guidelines)	☐	**YES** (the procuring agency general counsel MUST sign an analysis of this procurement using the TCRS analysis guidelines)
CONTRACTOR SIGNATURE			
CONTRACTOR		**DATE**	

6.1.1. Attachment 1

ATTACHMENT 1

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	
FEDERAL EMPLOYER IDENTIFICATION NUMBER (or Social Security Number):	

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

SIGNATURE & DATE:

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.

6.1.2. Attachment 2

6.1.2.1. Contractor Incentive - Performance-Based Contract and Damages

To effectively manage contractual performance, the Bureau must establish 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. These measures are meant to effect performance incentives for the Contractor, to support all activities required to operate and enhance the TCMIS infrastructure.

6.1.2.1.1. Contractor Incentive - Performance Management and Measures

The Contractor will 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;
- Improve the State and federal government return on investment for administration of the TennCare program.

The Bureau will identify areas of Contractor performance where quality is critical to the mission of the TennCare Program.

During Contract implementation, the Bureau will reach agreement with the Contractor concerning the critical areas of performance, performance standards, and levels of quality that are desirable, acceptable and substandard. The agreement concerning critical areas of performance, performance standards, and levels of quality, between the Contractor and the Bureau, must be reached ninety (90) days prior to the start of operations. If agreement is not reached during this time, the incentives will not take effect on the start of operations. Additionally, the annual incentive will 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 will 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 will be memorialized in an official correspondence that will be filed with the Department of Finance and Administration, Office of Contract Review, and with the Comptroller of the Treasury.

The Contractor will develop and/or install a Performance Reporting System as a means to measure quality levels on a monthly basis.

The Bureau will establish a range for Contractor performance for high quality, acceptable quality, and performance that will require corrective action on the part of the Contractor.

During the course of the Contract, performance standards will be measured by the Bureau, using the Performance Reporting System.

Bureau Contract Management will actively participate with the Contractor in using the Performance Reporting System and will approve the results recorded.

6.1.2.1.2. Approach to Performance Standards and Damages

6.1.2.1.2.1. The Bureau will identify areas of Contractor performance where quality is critical to the mission of the TennCare Program. For example, a Provider Report Card may be developed with key indicators for measuring Customer Service performance levels, provider enrollment turnaround timeframes, and/or satisfaction with training provided at workshops.

6.1.2.1.2.2. During Contract implementation, the Bureau will 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. The Bureau and Contractor will develop means to measure those critical areas of performance, performance standards, quality levels on a monthly basis, using the Performance Reporting System. The agreement concerning measurement of the critical areas of performance, performance standards, and levels of quality between the Contractor and the Bureau, must be reached ninety (90) days prior to the start of operations. If agreement is not reached during this time, the incentives will not take effect on the start of operations. Additionally, the annual incentive will 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 will be the later of the start of operations or ninety (90) days after the agreement between the Bureau and the Contractor concerning the measurement of critical areas of performance, performance standards, and levels of quality. The agreement will be memorialized in an official correspondence that will be filed with the Department of Finance and Administration, Office of Contract Review, and with the Comptroller of the Treasury.

6.1.2.1.2.3. The Contractor will 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.

6.1.2.1.2.4. The automated reports will 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.

6.1.2.1.2.5. During the course of the Contract, the Contractor will measure performance using the Performance Reporting System. Bureau Contract Management staff will actively participate with the Contractor in the performance reporting process and will approve the results recorded.

6.1.2.1.2.6. Critical areas of performance, performance standards, levels of quality, and the associated measurements will 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 must be completed and agreed upon at least forty-five (45) days prior to the beginning of the subsequent quarter. If agreement is not reached at least forty-five (45) days prior to the beginning of the subsequent quarter, the incentive will not be effective the subsequent quarter. Additionally, the annual incentive will be decreased by one-fourth (1/4) for any quarter when the incentive is not effective at the beginning of the quarter. The agreement will be memorialized in an official correspondence that will be filed with the Department of Finance and Administration, Office of Contract Review, and with the Comptroller of the Treasury.

6.1.2.1.2.7. At the end of each reporting period, the Performance Reporting System results will be posted on the TennCare intranet.

6.1.2.1.2.8. An independent, accredited auditing firm will review all audit reports on an annual basis.

6.1.2.1.2.9. The Bureau will monitor the Contractor's performance using a Performance Reporting System. This is an effective way to monitor the quality of the Contractor's performance, document performance levels in all critical areas of the system, facilitate the management of the Contractor's Contract and enhance the investment made by the State and federal government in the administration of the TennCare Program.

Each performance measure will have its own scoring mechanism established through negotiation with the Contractor and the Bureau and will consist of scoring elements totaling one hundred (100) points. For each of the performance measures, the number of points scored will 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 will be required for performance measures that score seventy-seven (77) or below.

Liquidated and actual damages will be assessed for performance measures that are not resolved based on the Contractors corrective action plan.

6.1.2.1.3. Right to Assess Damages

The Bureau may assess damages based on assessment of the Contractor's success in meeting required performance standards by the Bureau Contract Administrator. The Contractor must agree to 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 will be followed:

1) Contract management may first discuss the issues verbally with Bureau management.

2) Contract management may submit a written document to propose a corrective action plan to remedy the deficiency.

3) The Bureau may elect to present the issue to the Deputy Commissioner of TennCare and ask that they meet with Contractor management for issues resolution or damage assessment.

If damages can be measured in actual cost, they are referred to as actual damages. If the damages are difficult to measure or cannot be measured in actual cost, they are referred to as liquidated damages.

4) The Bureau will 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.

6.1.2.1.4. 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. 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 part 6.1.2.3.3 of Attachment 2 of the Contract.

6.1.2.1.5. Dispute Resolution Process for Damage Assessments

The Bureau expects that any disputes arising under the Contract will 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.

Venue for disputes will 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.

6.1.2.2. Liquidated Damages

6.1.2.2.1. Damage Provisions

All requirements described in the Contract are subject to monitoring by the Bureau of TennCare. The Contractor shall track and comply with all performance measures, commitments and requirements. The Bureau of TennCare 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 of TennCare's discretion.

6.1.2.2.2. Liquidated Damage - Failure to Meet Contractor Performance Requirements

It is agreed by the Bureau of TennCare and the Contractor that, in the event of a failure to meet the performance requirements listed in the following sections, damage is deemed to be 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 will pay the Bureau for such failures at the sole discretion of the Bureau of TennCare 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 cure period, written notification of each failure to meet a performance requirement will be given to the Contractor by the Contract Administrator. The Contractor shall have five (5) business days from the date of receipt of the written notification of a failure, to perform to specifications to affect the cure of the failure. The cure must be received by close of business on the fifth day. The Bureau may approve additional days, if deemed necessary, at its discretion. Liquidated damage may be imposed retroactively to the date of failure to perform and continue for the period of time until the cure is affected, and the Bureau has accepted the cure as approved. The imposition of liquidated damage is not in lieu of any other remedy available to the Bureau of TennCare.

Liquidated damages may not be assessed against the Contractor in those instances where the Bureau determines that inconsequential damage has occurred.

6.1.2.2.2.1. Assessments During Transition and Implementation

Failure to complete, by the expected delivery date and present to the Bureau any of the TCMIS Assessments, or parts thereof, required during Transition and Implementation, shall result in nonpayment to the Contractor for that Assessment and damages may be assessed by the Bureau.

6.1.2.2.2.2. Operational Start Date - Performance Requirement

It is the Bureau's intent to have the takeover of the TCMIS fully operational on January 1, 2009. Fully operational means to begin processing correctly all claim types, claims adjustments, and other financial transactions; maintaining all system files; producing all

required reports; and performing all other Contractor responsibilities specified in this Contract.

Compliance with the January 1, 2009 date is critical to the Bureau's interest. Therefore, the Contractor shall be liable for resulting damages if this date is not met. The Contractor's capability to meet this date shall be determined by the Bureau following the conclusion of the operational readiness test.

6.1.2.2.2.3. Operational Start Date – Damages

If, for any reason, the Contractor does not fully meet the operational start date approved in the Detailed Project Work Plan and a Contract amendment delaying this date or start-up or a portion of the processing requirements has not been approved, then the Contractor shall be liable for all costs incurred by the Bureau to continue current TCMIS and Contractor operations. The Contractor shall also forfeit all claims to reimbursement of monthly expenses or operational payments for that month and each month thereafter until the Bureau approves operational readiness, which shall not be unduly withheld.

6.1.2.2.2.4. Deliverables

For any Deliverable not completed and submitted to, and accepted by the Bureau by the expected completion date, payment shall not be made to the Contractor. In addition, damages may be assessed by the Bureau.

6.1.2.2.2.5. Sanctions by CMS – Consequential Damages

If CMS imposes fiscal sanctions against the Bureau as a result of the Contractor's or any subcontractor's action or inaction, the Contractor shall compensate the Bureau the amount lost by the Bureau by application of the sanctions.

6.1.2.2.2.6. Major Enhancements

Failure to develop and implement any of the major System Enhancements to the TCMIS by the expected 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 the enhancement and damages may be assessed by the Bureau.

6.1.2.2.2.7. Recovery

If, in the reasonable judgment of the Bureau of TennCare, 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 must 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.

6.1.2.2.2.8. Performance Monitoring

Requirements:

The Contractor is required to meet the requirements of the Contract in all areas measured by the Performance Reporting System.

The liquidated damages for performance measure areas that score below seventy-seven (77) will be five thousand dollars ($5,000) for each deficient area.

The liquidated damages for performance measure areas that score below seventy (70) will be ten thousand dollars ($10,000) for each deficient area.

6.1.2.2.2.9. Milestones or Phases

Requirements:

Unless otherwise specified, milestones and phases that occur during the Planning, Design, Development, Testing, and Implementation Phases must be completed by the Contractor in final form on the dates specified in the Contractor's Work Plan. The Bureau must review and provide written acceptance of all milestones or phases.

The liquidated damages will be one thousand dollars ($1,000) per workday for each day the milestone or phase is late or unacceptable.

6.1.2.2.2.10. 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 will contain a statement indicating sponsorship by the Contractor and the Bureau.

The liquidated damages will be five thousand dollars ($5,000) per incident in which the Bureau approval is not obtained.

6.1.2.2.2.11. HIPAA Compliance

Requirements:

The Contractor must ensure it meets all federal regulations regarding standards for privacy, security, and individually identifiable health information as identified in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 as specified in the Facilities Management General Operations Section of this Contract: (A.3.20).

The Contractor must deliver, maintain and operate the TCMIS in full compliance with the Health Insurance Portability and Accountability Act (HIPAA). (EDI Section of this Contract: A.3.19)

The Contractor is responsible for HIPAA compliance of the TCMIS and the Facilities Manager 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 the HIPAA standards shall be any penalties that the Bureau is assessed.

6.1.2.2.2.12. Performance Reporting System Report

Requirements:

The Contractor must 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 will be five hundred dollars ($500) a day for each workday the report is not received or acceptable.

6.1.2.2.2.13. 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 will 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 Contract Terms may be deducted during the entire period that MMIS certification is lacking. Should certification subsequently be granted retroactively, the Bureau will reimburse the Contractor for any amounts that have been withheld due to lack of certification.

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 will notify the Contractor in writing on or before the date the Bureau deducts such sums from money payable to the Contractor.

6.1.2.2.2.14. Information Analyst Thresholds

Requirement:

The Contractor is required to meet the minimum staffing level requirements of the Contract for the positions of Information Analysts and Specialists, (including senior levels). These staff members must work the minimum threshold hours as listed in paragraph section A.6.2.1.

Liquidated Damage Assessment:

If the Contractor fails to comply with this requirement, the liquidated damage assessment will be the average hourly rate for excess staffing for Information Analyst (see section C.3.4) multiplied by the sum of the required number of hours less the hours worked.

6.1.2.2.2.15. Business Services Analyst Thresholds

Requirement:

The Contractor is required to meet the minimum staffing level requirements of the Contract for the positions of Business Services Analysts, (including senior and advanced levels). These staff members must work the minimum threshold hours as listed in paragraph section A.6.2.1.

Liquidated Damage Assessment:

If the Contractor fails to comply with this requirement, the liquidated damage assessment will be the average hourly rate for excess staffing for Business Service Analyst (See section C.3.4) multiplied by the sum of the required number of hours less the hours worked.

6.1.2.2.2.16. Project Manager Thresholds

Requirement:

The Contractor is required to meet the minimum staffing level requirements of the Contract for Project Managers, The Project Managers must work the minimum threshold hours as listed in paragraph section A.6.2.1.

Liquidated Damage Assessment:

If the Contractor fails to comply with this requirement, the liquidated damage assessment will be the average hourly rate for excess staffing for Project Managers (See section C.3.4) multiplied by the sum of the required number of hours less the hours worked.

6.1.2.2.2.17. Other Staffing Level Thresholds

Requirement:

The Contractor is required to meet the minimum staffing level requirements of the Contract for maintenance and user support staff. These staff members must work the minimum threshold hours as listed in paragraph sections A.6.2.2 and A.6.4.

Liquidated Damage Assessment:

If the Contractor fails to comply with this requirement, the liquidated damage assessment will be the average hourly rate for excess staffing for deficient staffing level multiplied by the sum of the required number FTE hours less the FTE hours worked (Formula = Average hourly rate x ((FTEs required x 1,770)-(FTEs used x 1,770)).

6.1.2.2.2.18. On-Site Staffing Assessment

Requirement:

The Contractor is required to meet the on-site staffing requirements as depicted in the table in paragraph section A.6.2.2.

Liquidated Damage Assessment:

If the Contractor fails to comply with this requirement, the liquidated damage assessment will be twenty-five dollars ($25) per hour, per staff position that the staff members were not available on-site.

6.1.2.2.2.19. Dedicated Staffing Assessment

Requirement:

The Contractor is required to meet the dedicated staffing requirements as depicted in the table in paragraph section A.6.2.2.

Liquidated Damage Assessment:

If the Contractor fails to comply with this requirement, the liquidated damage assessment will be twenty-five dollars ($25) per hour, per staff position that the staff members were not dedicated to the TCMIS account.

6.1.2.2.3. 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 of TennCare. The Bureau and Contractor agree that any delay or failure by Contractor to timely perform its obligations by the dates in the Work Plan and in accordance with the Performance Commitments will interfere with the proper and timely transition 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 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 fails to meet performance commitments during the Warranty Period 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.

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.

6.1.2.2.3.1. MMIS Certification

The TCMIS System, and all of its subsystems and components, must 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 by the start of the Operations as of January 1, 2009. Federal certification shall be requested retroactively to the start of full Contractor and system operations. 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 must 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 shall 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 decision is received in writing.	Retroactive to Contract Start date.	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 shall 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 must 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 Contract start date.	Whatever damages or penalties CMS assesses.	Any FFP damages (which is the difference between the maximum allowable FFP and that actually received by the Bureau over the same time period).

6.1.2.2.3.2. Change Management

The TCMIS Facilities Management Contractor is responsible for identifying changes in applicable federal or State legislative enactments and regulations and the impact of such changes on the performance of the Services or Deliverables or the Bureau's use of the Facilities Management services or deliverables. The Contractor must timely notify the Bureau of such changes and must work with the Bureau to identify the impact of such changes on how the Bureau uses the Services or Deliverables. It is 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 the Contract meet the requirements.

Reference or Contract section – Listed below:

A.2 Transition/Implementation of Facility Manager Operations

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 systems changes, including a three (3) month projection of SCRs.	If the report is not delivered by the defined date as specified according to the work plan.	Each month, according to the work plan.	One hundred dollars ($100) per calendar day for each day the SCR report is not received timely in the Regular Status Report. If the report is received on time but the information reported is inaccurate or incomplete, the Bureau shall assess up to one hundred dollars ($100) per day until an acceptable report is received.	

Change Management Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
Contractor shall provide monthly report of staff time spent by job category on system modifications / enhancements.	Produce a monthly staffing report.	Each month, according to project schedule.	One hundred dollars ($100) 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 shall assess up to one hundred dollars ($100) per day until an acceptable report is received.	
Contractor must provide written response to Bureau requested change request estimates within three (3) business days	Produce Change Request response information.	Within three (3) business days of Bureau request.	One hundred dollars ($100) per day until an acceptable response is received.	
Contractor must provide SCR status meeting minutes within two (2) business days.	Produce and distribute meeting minutes within two (2) business days of SCR status meeting.	Within two (2) business days of SCR status meeting.	One hundred dollars ($100) per business day for each day past deliverable period.	
Maintenance request must	Produce correction to maintenance requests.	Within fifteen (15)	One hundred dollars	

Change Management Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
be corrected within fifteen (15) business days or by specified correction date		business days of maintenance request.	($100) per business day for each day past deliverable period.	
Contractor must have qualified staff available to support modification task activities.	Provide qualified staff to work on modification activities.	Each day.	One hundred dollars ($100) per day per each staff position that staff is unavailable.	Refer to parts 6.1.2.2.2.14 through 6.1.2.2.2.19 for detailed assessment criteria.
Contractor must track all stages of work performed (e.g. dates, staff assigned, priority)	Produce a project tracking report that lists dates (e.g. assigned, completed), staff assigned, work status (e.g. coded, tested) that demonstrates change management tracking.	Each week according to work plan.	One hundred dollars ($100) per day for each day past deliverable period, unless waived by the Bureau.	

6.1.2.2.3.3. Claims Reporting and Financials

The TCMIS Facilities Manager Contractor is responsible for the overall support and reporting for all of the claims processing and financial activities necessary to support the Tennessee medical assistance programs. This 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 following subsection listed below describes the Claims Reporting and Financial-related activities. This list may not be all inclusive: it is the responsibility of the Contractor to ensure all Claims Reporting and Financial 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 following table lists the operational responsibilities and performance expectations that the Bureau has for Claims related activities.

Claims Table

Claims Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
Contractor shall be responsible for timeliness of	Claims File or financial transaction is more than four (4)	Four (4) hours after the claims	($1,000) per hour for each hour (or fraction thereof)	

Claims Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
payments	hours past specified timeframe for transmission.	transactions are produced.	the file is transmitted late, up to four (4) hours. Ten thousand dollars ($10,000) for each transmission later than four (4) hours and for any transmission that cannot be processed due to the quality of the file transmitted.	
Contractor shall be responsible for timeliness of Claims Processing. One hundred percent (100%) of claims must be processed and adjudicated within sixty (60) days from the date of receipt of the claim.	Failure to meet the requirements for four (4) consecutive months could result in an assessment of damages of seventy thousand dollars ($70,000).	Four (4) consecutive months of Contractor's failure to meet claims processing requirements.	Ten thousand dollars ($10,000) may be assessed for the first month of each failure to meet requirements. Twenty thousand dollars ($20,000) may be assessed for each consecutive subsequent month a requirement remains unmet, up to seventy thousand dollars ($70,000).	
Contractor is liable for the actual amount of overpayment not recovered, if caused by Contractor.	Whenever the amount of overpayment or underpayment is inaccurate.	Sixty (60) days from the date the over or under payment is identified.	Liquidated damage will be the actual amount of overpayment not recovered due to Contractor error.	
Contractor shall be liable for the amount of duplicated payments.	A duplicate payment is made and not corrected within sixty (60) days of discovery.	Sixty (60) days from the date the duplicate payment is identified.	True amount of duplicate payment(s).	
Contractor may propose a Corrective Action Plan (CAP) upon notice of a payment transaction deficiency.	If agreed upon remedy is deficient, (the Contractor fails to complete the mutually agreed upon CAP), liquidated damage will be assessed.	Date varies depending on the specified date that CAP remedy is due.	Twenty-five percent (25%) of the current price per suspense transaction for each receipt that remains unprocessed below the threshold up to a maximum of five thousand dollars ($5,000) per month.	

6.1.2.2.3.3.1. Claims Control and Entry Functions

The Claims Control and Entry functions ensure that all paper claims, including UB92, 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 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 includes 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.

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.	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 day of receipt.	Produce a report with a random sample 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.	One hundred dollars ($100) per 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.	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	Produce a report with a random sample of all reports with the date the report was	Within one (1) business day of report	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
report generation.	generated and the date the report was imaged.	production.		
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.	One hundred dollars ($100) per day per batch for each day past deliverable period.	
Enter all paper claims within three (3) 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 three (3) business days of claims receipt.	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.	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 dashboard, or hardcopy if requested by the Bureau.	Daily, or as frequently as claims are received.	One hundred dollars ($100) per day per report for each day past deliverable period.	
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 dashboard. If requested by the Bureau, hard copy claims statistical reports.	Daily, weekly, & monthly: as frequently as claims are received.	One hundred dollars ($100) per statistical report for each day past deliverable period.	

6.1.2.2.3.3.2. Reconsiderations

According to provider appeal policies the provider can resubmit Institutional, Professional, or Pharmacy claims for reconsideration of claims payments or timely filing issues. The Facilities Manager must reprocess these claims, determining if any errors occurred during initial payment processing or if any policies for payment were violated.

The following table lists the operational responsibilities and performance expectations that the Bureau has for Claims Reconsideration activities.

Claims Reconsiderations Table

Claims Reconsideration Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
Provide weekly reports on all reconsidered claims received by claim type and edit sets.	Publish all reports to the dashboard, or provide hardcopy if Bureau requests.	Weekly, by noon CST on the following business day following the claims receipt.	One hundred dollars ($100) per day per report for each day past deliverable period.	
Resolve reconsiderations claims within fifteen (15) days of receipt, or according to Bureau guidelines.	Produce a report with a random sample of all reconsiderations with the date the claim was received and the date the claim was resolved.	Within fifteen (15) days of reconsideration receipt.	One hundred dollars ($100) per day per reconsideration for each day past deliverable period.	
Provide monthly reports on paid, denied, and suspense reconsiderations per Bureau requirements.	Publish all reports to the dashboard or by hardcopy if Bureau request.	Monthly, by Noon on the next business day following the processing.	One hundred dollars ($100) per day per report for each day past deliverable period.	

6.1.2.2.3.3.3. 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 accepts claims/encounters entered through the claims control and entry process, performs extensive validity checks (edits and audits), and adjudicates and prices approved claims according to Bureau policy. Claims pricing and adjudication is 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 automatically calculates the allowed amount for claims and encounters according to Bureau policy. The pricing function includes 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) Medical Policy Resolutions - Claims are screened against pended claims and paid/denied claims (claims history), eligibility, provider, procedure, diagnosis, edit/audit, and pricing files. Claims exceeding the limits or audit criteria on these files are reviewed by Contractor or Bureau staff using the Bureau-approved

adjudication guidelines. Corrections to claims are made and applied to the claim record. Claims that do not exceed any of the file limits or audit criteria are 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 are maintained for each enrollee. Health insurance payments, estate recovery actions, SUR audits, or other adjustments to claims are also maintained. This information is maintained online then archived for storage according to a Bureau-defined schedule. Certain claims, such as those for once-in-a-lifetime surgical procedures, are never purged from online claims history.

6) The Encounter processing function processes encounter claims as health plan encounter records submitted to the TCMIS under the Bureau's managed care program. This function accepts, edits, prices, and processes encounter claims in accordance with Bureau edit guidelines. Encounter processing has limited auditing and history update, and bypasses the remittance and check write flow.

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 dashboard that demonstrate the Contractor meets all CMS and audit processing requirements.	Agreed upon timeframe whenever required by CMS and the Bureau.	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.	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.	One hundred dollars ($100) per day for each day past the deliverable period, unless waived by the Bureau.	

Claims / Encounter Adjudication Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
Process claims received according to the following standards: Ninety percent (90%) within thirty (30) calendar days of receipt in the Contractor's mailroom or by electronic transmission.	Produce a report that documents the percent of Claims processed within thirty (30) days and sixty (60) days by claim receipt date.	Ninety (90%) within thirty (30) calendar days of receipt in the Contractor's mailroom or by electronic transmission, or remainder within sixty (60) days.	One hundred dollars ($100) per claim that is not adjudicated within the specified timeframes.	One hundred percent (100%) of clean paper claims within sixty (60) calendar days of receipt in the Contractor's mailroom or by electronic transmission.
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.	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.	One hundred dollars ($100) per day per document or transaction for each day past the deliverable period.	

6.1.2.2.3.3.4. 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.

The outputs of the Claims Reporting and Financial Processing function shall meet all federal and State reporting requirements, and will provide the information necessary to assess compliance with federal certification and audit review standards. The outputs will 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
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.	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 forty-five (45) calendar days and within two (2) business days after the most current payment processing cycle.	Produce a report that documents the date EOMBs are sent to enrollees and the time frame between the last time EOMBs were sent.	At least every forty-five (45) calendar days for EOMBs, within two (2) business days after claims cycle.	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	Publish all reports to the dashboard, or by hardcopy if requested by the Bureau.	Daily, or according to the frequency of claims	One hundred dollars ($100) per day per claims cycle report for each day past deliverable period.	

Claims Reporting, Financial processing Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
other reports after each claims processing cycle.		processing cycle.		
Make available all financial reports for online viewing to the Bureau within one (1) business day of the financial cycle.	Produce a report that documents the date the financial reports were made available on the dashboard and the date of the financial cycle.	Within one (1) business day of financial cycle.	One hundred dollars ($100) per day per financial report, that the reports are not available for online viewing.	
Produce, and submit to the Bureau, weekly reports on accounts receivable collections and outstanding balances, as approved by the Bureau.	Publish all reports to the dashboard, or hardcopy if requested by the Bureau.	Weekly by noon CST on the following business day following the production cycle.	One hundred dollars ($100) per day per report, that the weekly reports are late due to Contractor issues.	
Produce, and submit to the Bureau, weekly and monthly accounts receivable reports in aggregate and/or individual accounts, as approved by the Bureau.	Publish all reports to the dashboard or hardcopy if requested by the Bureau.	Weekly and monthly by noon CST on the third (3rd) business day following the production run.	One hundred dollars ($100) per day per report, that the Accounts Receivable (A/R) 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.	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 within twenty-five (25) calendar days of identification of the error, or as directed by the Bureau.	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 twenty-five (25) calendar days of identification, or as directed by the Bureau.	One hundred dollars ($100) per day per adjustment error if delayed from processing due to Contractor issues.	
Accommodate all	Produce a report	Within five	One hundred dollars	

Claims Reporting, Financial processing Commitment	Performance Indicator	Deliverable Period	Liquidated Damage	Additional Assessment Criteria
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.)	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.	(5) business days of scheduled process, or of Bureau request.	($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.	One hundred dollars ($100) per 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) quarterly.	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 quarterly.	One hundred dollars ($100) per day per systems change for which systems change / operations documentation / DSD is not updated.	
Immediate notification to the Bureau upon discovery of any overpayments, underpayments or duplicate payments, irrespective of cause.	Produce a report when problems occurred and when the Bureau was actually notified.	Upon discovery of incorrect payments.	The Contractor shall be liable for the actual amount of the Contractor-caused overpayments that are not recovered. The actual amount of the outstanding overpayment will be deducted from Contractor payments.	

6.1.2.2.3.4. General Subsystems/TCMIS

The TCMIS Facilities Manager Contractor must 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

6.1.2.2.3.4.1. 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
Update Provider Subsystem operations manuals when system changes are made and DSDs quarterly.	Produce a report that lists all dates when system changes were made and dates when operations manuals were actually updated.	Monthly, or when requested by the Bureau, or at least quarterly.	One hundred dollars ($100) per day per systems change for which systems change / operations documentation / DSD is not updated.	
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.	One hundred dollars ($100) per day that the scheduled reports are not processed after scheduled or the Bureau requested date.	
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)	One hundred dollars ($100) per day that the AVRS component is not	

Provider Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
twenty-four (24) hours per day, seven (7) days per week.		days per week.	functioning correctly.	
Provide online access and updates to Provider data within normal business hours.	Notify Bureau management if online access is not available.	Daily	One hundred dollars ($100) per day that the Provider component is not available.	

6.1.2.2.3.4.2. 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 1) 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, 2) to accomplish automated interfaces with other systems, and 3) to 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 is maintained by the Contractor in an electronic file in the TCMIS. Updates to this file are 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 update process by noon CST on the business day following the update.	Produce a report that lists the report name, documents the delivery date and time of all reports, and the Bureau staff member that received the report.	Daily, by noon CST on the business day following the update.	One hundred dollars ($100) per day that the scheduled reports are not delivered according to schedule.	
Produce, and submit to the Bureau, balancing and maintenance reports from the weekly update process by noon	Produce a report that lists the report name, documents the delivery date and time of all reports, and the Bureau staff member that received the	Weekly, by noon CST on the business day following the update.	One hundred dollars ($100) per day that the scheduled reports are not delivered according to schedule.	

Eligibility Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
CST on the business day following the update.	report.			
Produce, and submit to the Bureau, balancing and maintenance reports from the monthly reconciliation process by noon CST on the third (3rd) business day following the run.	Produce a report that lists the report name, documents the delivery date and time of all reports, and the Bureau staff member that received the report.	Monthly, by noon CST on the third (3rd) business day following the update.	One hundred dollars ($100) per day that the scheduled reports are not delivered according to schedule.	
Update system and operations documentation when system changes are made and DSDs quarterly.	Produce a report that lists all dates when system changes were made and dates when operations manuals were actually updated	Monthly, or when requested by the Bureau, or at least quarterly.	One hundred dollars ($100) per day per systems change for which systems change / operations documentation / DSD is not updated.	
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.	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.

6.1.2.2.3.4.3. Correspondence, Letters and Notices

The 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

Correspondence Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Ensure production of correspondence,	Produce a report that contains	Within twenty-four	One hundred dollars ($100) per	

Correspondence Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
letters and notices are within twenty-four (24) hours of receipt of print files.	correspondence statistics, along with random samples of each type of correspondence for verification.	(24) hours of receipt of print files.	day until correspondences are produced.	
Mail outgoing correspondence at the most cost effective postage rate within twenty-four (24) hours of receipt of printed materials, or within Bureau specified timeline.	Produce postage/mail report that lists correspondence information (e.g. rate, mail date, type of correspondence, quantity).	Within twenty-four (24) hours (or Bureau specified timeline) of receipt of printed materials.	One hundred dollars ($100) per day until correspondences are mailed.	Ensure that the most cost effective postage rate is used.
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 processing).	Within twenty-four (24) hours (or Bureau specified timeline) of receipt of printed documents.	One hundred dollars ($100) per day until correspondences are verified.	

6.1.2.2.3.4.4. EPSDT

The Contractor must 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.	One hundred dollars ($100) per day until notices are produced and mailed.	
Produce quarterly CMS-416 EPSDT report according to federal requirements.	If the report is not produced within five (5) business days of due date (according to production schedule), or is inaccurate, the Bureau may assess damages until remedied.	Quarterly and Annual, according to schedule.	One hundred dollars ($100) per day after the due date until report is produced.	The Contractor shall be responsible for any related damages federally imposed on

EPSDT Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
				the Bureau.
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.	One hundred dollars ($100) per day after the due date until updates are processed.	

6.1.2.2.3.4.5. 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	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	One hundred dollars ($100) per day after the due date until payments are generated.	The Contractor shall be responsible for any related damages federally imposed on the Bureau.

6.1.2.2.3.4.6. 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
Enter all batch and online updates within Bureau-defined time frames.	Produce a report that contains all batches and a random sample of online updates that show receipt date and the actual time frame for completion.	Within five (5) business days of update receipt.	One hundred dollars ($100) per day after the due date until updates are processed.	
Correctly apply all reference file/database 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 (5) business days of interface / update receipt.	One hundred dollars ($100) per day after the due date until updates are processed.	
Deliver weekly, monthly, bimonthly, and quarterly reports, as defined by the Bureau, including specially requested reports.	Produce a report that lists the report name, documents the delivery date and time of all reports, and the Bureau staff member that received the report.	Within five (5) business days of update receipt.	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.	One hundred dollars ($100) per day after the due date until update is processed.	

6.1.2.2.3.4.7. 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
Correctly adjudicate (90% of FFS claims within thirty (30) calendar days of receipt and 100% of FFS claims within sixty (60) days of receipt.	Produce a report that documents the percent of Claims processed within thirty (30) days and sixty (60) days by FFS claim receipt date.	Within thirty (30) calendar days of receipt	One hundred dollars ($100) per day after the due date until updates are processed according to requirements.	
Adjudicate 100% of EDI clean claims within twenty-one (21) calendar days.	Produce statistical report that documents the percent of EDI claims processed, showing time periods for adjudication.	Within twenty-one (21) calendar days of processing EDI claims.	One hundred dollars ($100) per day per claim that is not adjudicated within twenty-one (21) calendar days of receipt.	
Adjudicate 100% of clean paper claims within thirty (30) calendar days.	Produce statistical report that documents the percent of paper claims processed, showing time periods for adjudication.	Within thirty (30) calendar days of processing paper claims.	One hundred dollars ($100) per day per claim that is not adjudicated within thirty (30) calendar days of receipt.	
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.	One hundred dollars ($100) per day per provider that notifications are not generated.	
Ensure assignment of a unique claim reference number within one (1) business day of receipt.	Produce audit report that documents the assignment of claim reference numbers and the date received.	Within one (1) business day of claim receipt.	One hundred dollars ($100) per claim reference number that is not assigned within the required time period.	
Update claims data returned by providers within three (3) business days of receipt.	Produce statistical report that documents the claims data returned by providers.	Within three (3) business days of receipt.	One hundred dollars ($100) per day per claim that is not returned to providers within the required time period.	

6.1.2.2.3.4.8. 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 will 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 via electronic data transmission. All claims submitted through electronic transactions will be edited against the most current enrollee, provider,

and reference files/database tables. Claims are assigned transaction control numbers immediately upon receipt and are downloaded nightly to the TCMIS for processing. Claims failing these edits are 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.	Produce a report with a 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.	One hundred dollars ($100) per response that exceeds the time limitation.	
Notify providers by a confirmation notice within sixty (60) seconds or less for batch transactions through standard X12N transactions.	Produce a report with a random sample 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 sixty (60) seconds or less for batch transactions.	One hundred dollars ($100) per response that exceeds the time limitation.	
Update the claims entry files daily with electronic transaction-submitted claims.	Produce a report of random sample of claims updated every day.	Daily	One hundred dollars ($100) per day that the electronic transactions are not processed daily, unless approved by the Bureau.	
Produce and submit to the Bureau, all electronic claims submission reports by noon on the business day following the report run.	Publish all reports to the dashboard, or hardcopy as requested by the Bureau.	By noon next business day.	One hundred dollars ($100) per report per day if not received.	
Load electronically submitted claims within one (1) business day of receipt by the	Produce a report with a random sample of all electronically submitted claims with the date and time the	Within one (1) business day of receipt by the	One hundred dollars ($100) per claim per day if not loaded.	

Electronic Transactions Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Contractor.	claim was received and the date and time the claim was loaded.	Contractor.		
Process all batch submittals by 8:00 a.m. CST the day after receipt.	Produce a report with a random sample of all batch submittals with the date and time the batch was received and the date and time the batch was loaded.	Within four (4) hours after the 8:00 a.m. CST due time.	One hundred dollars ($100) per day per batch.	

6.1.2.2.3.4.9. 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 tracks pharmacy claims for drugs and invoices drug manufacturers using drug information and rebate amounts specified by CMS. The TCMIS generates quarterly invoices to drug manufacturers.

The Drug Rebate Subsystem maintains drug manufacturer information, records and remittance advices received from manufacturers with their rebate payments, and tracks manufacturers' adjustments and disputes, and dispute resolution. It also provides a crosswalk of C, J, Q, and S HCPC codes.

The Drug Rebate Subsystem maintains 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 contains 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 allows a user to manually adjust invoice line items to assist in the adjustment and dispute resolution processes. The invoice history database also provides an audit trail of the manually entered adjustments and flags them for inclusion on the next adjustment invoice. Data is maintained on the invoice history database for a minimum of eighty-four (84) months. All disputed codes will be kept on the database until resolved.

Drug Rebate automatically assesses 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 is not calculated on items in dispute, but is charged after the dispute is resolved. Interest is 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	Produce a report that	Within one	One hundred	

Drug Rebate Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Drug Rebate file within one (1) day of receipt.	lists the date the CMS drug rebate file was received and the date the CMS drug file was processed.	(1) day of receipt	dollars ($100) per file if not processed within required time period, due to Contractor issues.	
Generate invoices and send to Bureau for review within three (3) days of the completion of the drug rebate cycle.	Produce a report that lists the date when the drug rebate cycle was completed and the date the drug rebate cycle invoices were generated.	Within three (3) days of the completion of the drug rebate cycle.	One hundred dollars ($100) per day if invoices are not sent to Bureau for review, due to Contractor issues.	
Mail invoice statements to manufacturers within sixty (60) days of the end of the calendar quarter.	Produce a report that lists the date when the drug rebate invoice statements were mailed to manufactures and the quarter for the invoice.	Within sixty (60) days after the end of the calendar quarter.	One hundred dollars ($100) per day if invoices are not mailed due to Contractor issues	
Perform claims audits throughout the quarter. Perform invoice audits and generate report on disputed claims and invoices prior to generating CMS files. Send report to Bureau for review and approval before generation of the CMS file.	Produce a report with the dates of each audit performed throughout the quarter.	Within ten (10) business days prior to generation of CMS Quarterly file.	One hundred dollars ($100) per day if invoice audits are not sent for review.	
Generate rebate reporting file, and send file to Bureau for review and approval, after claims and invoice audits but before generation of the CMS file.	Produce a report that lists the date when the rebate reporting file was sent to the Bureau and when CMS file was generated.	Within ten (10) business days prior to generation of CMS Quarterly file.	One hundred dollars ($100) per day if rebate reporting data is not sent for Bureau review.	
Generate manufacturer drug rebate file to CMS within ninety (90) days of the end of the calendar quarter.	Produce a report that lists the date when the manufacture drug rebate file was sent to CMS and the quarter for the drug rebate file sent to CMS.	Within ninety (90) days of the end of the calendar quarter.	One hundred dollars ($100) per day that rebate file is late.	

6.1.2.2.3.4.10. 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 ensures that the medical assistance programs are the payer of last resort. This is 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 will use information gathered from a number of sources to identify liability for medical services. These 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 are maintained to obtain additional information related to third-party resources.

The Facilities Manager will be responsible for most automated processes related to TPL. In addition, some manual TPL-related functions are to be handled by the Facilities Manager with ongoing coordination with the Bureau, primarily in the area of federally-mandated post-payment recovery. Bureau staff have 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.

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, Health Management System, (HMS) on a weekly basis.	Produce a report that lists the date when the HMS information was received and the date the files were processed.	Weekly, within twenty-four (24) hours of receipt.	One hundred dollars ($100) per day if TPL data from HMS is not processed when received, due to Contractor issues.	
Update the carrier file/database table with information received from HMS 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 HMS information was received and the date and time the files were processed.	Within twenty-four (24) hours of receipt of a request.	One hundred dollars ($100) per day if carrier data from HMS is not processed when received, due to Contractor issues	
Provide monthly status summaries	Produce a report that lists when status	By the tenth (10th) day	One hundred dollars ($100) per	

TPL Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
of post-payment recovery billings to the Bureau by the tenth (10th) day of each month.	summaries were created and the date when they were actually reported to the Bureau.	of each month.	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.	One hundred dollars ($100) per request of imaged document.	

6.1.2.2.3.4.11. 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 manages:

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), Behavioral Heath Organizations (BHO), 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.

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 Contractor, the date the rates were processed, and the date of the next processing cycle after the rates were received.	Prior to the next 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	Produce audit reports to show system cycle process information.	Within four (4) hours of start of the following	One hundred dollars ($100) per day if managed care cycles are not	

Managed Care Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
the following business day.		business day,	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.	One hundred dollars ($100) per day if extract files are not received according to required timeframes, due to Contractor issues.	

6.1.2.2.3.4.12. Management and Administrative Reporting (MAR)

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 will 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.	One hundred dollars ($100) per day if MAR reports are not received according to required timeframes, due to Contractor issues.	
Save final output files for at least twelve (12) months.	Produce a report that lists date final output files were produced and the date when they were discarded.	Twelve (12) month period.	One hundred dollars ($100) per day per report if MAR reports are not retained.	
Respond to Bureau requests for information about the reports with a resolution no later than three (3) business days after the request.	Produce a report that lists the date when the report request was received and the date when the report response was received.	Within three (3) business days of request.	One hundred dollars ($100) per day per report resolution.	
Perform necessary corrections, rerun,	Reproduce corrected reports.	Within three (3) business	One hundred dollars ($100) per	

MAR Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
verify, and distribute management reports within three (3) business days of problem identification.		days of problem identification.	day per report.	
Generate accurate CMS reports by no later than six (6) weeks prior to the federal deadline.	Produce CMS reports within required timeframe.	Within six (6) weeks prior to the federal deadline.	One hundred dollars ($100) per day per report that CMS reports are late due to Contractor issues.	

6.1.2.2.3.4.13. Surveillance and Utilization Review (SUR)

The SUR function identifies, reports and supports the investigation of potential misuse of the medical assistance programs by providers and enrollees. The Surveillance and Utilization Review Subsystem (SURS) creates 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 analyzes historical data, develops profiles of health care delivery, and reports 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 provides 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 will be performed for the fee-for-service and the managed care programs. The Contractor will 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.	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	Contractor shall	By the fifth	One hundred	

SUR Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
deliver all monthly reports to the Bureau by the fifth (5th) business day following the day the SURS database was updated.	ensure that SURS reports are delivered by the specified timeframe.	(5th) business day following SURS database update.	dollars ($100) per report that is beyond the required time period, due to Contractor issues.	

6.1.2.2.3.5. General System Contractor Requirements

The TCMIS Contractor is expected to meet all of the general requirements listed in the subsections below during the term of the 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 the Contract meet the requirements.

Reference or Contract section – Listed below:

A.3.20 Facilities manager General operations

A.6 Staffing

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.	Five hundred dollars ($500) for each security / confidentiality breach occurrence.	Contractor is further liable for any damages imposed on the Bureau by the State or federal government.
Contractor must produce an acceptable Disaster Recovery Plan by specified time according to project schedule.	Contractor shall submit an acceptable Disaster Recovery Plan as required.	At contract start, and updated annually	One hundred dollars ($100) per calendar day for each day an acceptable Disaster Recovery Plan is not received timely, according to Project schedule.	Liquidated damages may be assessed for non-compliance of performance indicator.
Contractor shall conduct demonstration of Disaster	Disaster Recovery shall be demonstrated for completeness and approved by the	According to Project Plan, then annually	One hundred dollars ($100) per calendar day beginning the first	

General TCMIS Operations Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Recovery Plan	Bureau.	thereafter.	(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 must submit an Annual Business plan for Bureau acceptance.	Acceptable Annual Business plan is submitted to Bureau.	Contract start and annually thereafter.	One hundred dollars ($100) per calendar day for each day an acceptable Annual Business Plan is not timely received.	
Contractor must maintain Key Personnel according to the Contract requirements.	Contractor must keep Bureau informed of all staffing, and periodically submit updated organization charts.	Contract start, then at least quarterly thereafter, or as requested by the Bureau.	Up to a maximum of twenty-five thousand dollars ($25,000) per occurrence, taking into consideration the person's role and the expected impact on the system development, schedule or ongoing operations.	
Contractor must react to contract non-compliance issues.	Contractor must work with the Bureau to correct non-compliance issues, proposing corrective action plans or other curative measures by the specified date, else the Bureau may assess liquidated damages.	Dates specified in CAPs or according to timelines required by the Bureau.	One hundred dollars ($100) per business day after the due date until the non-compliance is corrected.	The Contractor will also be held responsible for any and all additional liquidated damages imposed on the Bureau by the State or federal government.
The Contractor must work with the Bureau to	Comply with Bureau requirements as a result of audit findings.	Dates will be specified by the	One hundred dollars ($100) per day after due date.	The Contractor will also be

General TCMIS Operations Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
comply with audit findings.		Bureau.		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.

6.1.2.2.3.6. Operations

The TCMIS Facilities Manager Contractor must operate and maintain the TCMIS system and perform the Contractor responsibilities listed in the subsections below. All TCMIS and Facilities Manager functions must 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 Takeover and Enhancements Project Management

A.2 Transition/Implementation of Facility manager Operations

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 meet the requirements as of the Start of Operations	If, for any reason, the Contractor does not fully meet the operational start date, then the Contractor shall not be reimbursed for operational payments for that month and each month thereafter until the	Contract operations start date: January 1, 2009	The additional cost shall be the per claim cost difference between the cost of continuing operations with the prior Facilities Manager (after January 1, 2009).	In addition, if the Bureau has not approved the start of operations of the TCMIS as of January 1, 2009, the Contractor will be liable for

General Operations Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
	Bureau approves the start of Facilities Management and Contractor TCMIS operations.			all additional costs incurred by the Bureau to continue current operations.
Contractor shall accept responsibility for the accuracy of systems and operations documentation	Contractor shall maintain all documentation and comply with delivery requirements.	Contractor Within thirty (30) days of Contractor start date, or Within five (5) calendar days of notice, to correct documentat ion.	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. If not corrected within five (5) calendar days of notice, assessment may occur from date of notification to date of correction.
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 and daily thereafter	One hundred dollars ($100) per day for each report.	

6.1.2.2.3.6.1. 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 the Contract. Nothing listed here supersedes other specific requirements listed within the 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, Contractor mail, reports, and other deliveries as specified by the Bureau. Pickups and deliveries shall be made once in the morning and once in the afternoon each business day, as specified by the Bureau.	Produce a daily report that lists the pick-up and delivery times.	Multiple times each business day: once in the morning and once in the afternoon, and as specified by the Bureau.	One hundred dollars ($100) per occurrence for each missed currier delivery.	Maintain a daily log and make available to the Bureau upon request.
Receive and date-stamp all Bureau mail within twenty-four (24) hours of receipt.	Produce reports that documents the number of mail pieces received daily and the number of mail pieces stamped within twenty-four (24) hours after the mail was received.	Within twenty-four (24) hours of receipt.	One hundred dollars ($100) for each occurrence.	
Document all 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. CST 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. CST the second (2nd) business day after the meeting.	One hundred dollars ($100) per day for each meeting report.	This summary should 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.	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 within five (5)	Produce a report that lists all requested extracts, the date the extract was requested, and the date the extract was delivered.	Within five (5) business days of the date requested.	One hundred dollars ($100) per day for each file request not delivered timely.	

General Manual Operations Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
business days of the date requested.				
Provide all Bureau-requested files and/or reports. The requested files and/or reports shall be supplied by the Contractor within five (5) business days of request.	Produce a report that lists all requested reports, the date the report was requested, and the date the report was delivered.	Within five (5) business days of the date requested	One hundred dollars ($100) per day for each file / report.	
Deliver daily, weekly, monthly, and annual reports according to the Bureau-approved schedule and media, and in accordance with the performance expectations defined in Subsection pertaining to Reports Production Requirements.	Produce a status report that lists all reports and the date the report was delivered and media that was used, if requested by the Bureau.	Daily, weekly, monthly, and annually	One hundred dollars ($100) per day for each report.	
Notify Bureau via email or by phone within five (5) minutes if the Contractor determines that the system is unavailable. The Contractor must also immediately notify the Bureau via email or by phone within five (5) minutes when the system is restored.	Produce an audit report that lists all times the system was unavailable and the date and time the Bureau was notified of the system unavailability and when the Bureau was notified of the system being restored with the date and time the system was restored.	Within five (5) minutes if the Contractor determines that the system is unavailable or restored.	One hundred dollars ($100) per day for each occurrence that the Contractor fails to notify key Bureau personnel.	

6.1.2.2.3.6.2. 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 will 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 will provide training when new system features or updates have presented significant change and will provide a training program for new users.

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 at least ten (10) Bureau user training sessions per month, as defined by the Bureau.	Produce a monthly report that lists the training sessions that occurred, the date the training sessions occurred, and the people that attended the training.	At least Monthly	One thousand dollars ($1,000) per month per session if training session is not conducted, unless waived by the Bureau.	
Computer Based Training (CBT) and Web Based Training (WBT) applications shall be accessible via a secured Internet logon environment.	Training applications are available for Bureau use.	Initial training by October 31, 2008, 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.	One hundred dollars ($100) day that applications are not available due to Contractor issues.	
Provide training plans and training materials to the Bureau for review, feedback, comments.	Produce a report that lists the first date of each training session and the delivery date of the training plans and materials for each training session.	One (1) month prior to delivery of a training session.	One hundred dollars ($100) per month that training materials / plans are not provided, unless waived by the Bureau.	
Provide the updated version of	Produce a report that lists any changes	Within ten (10) business	One hundred dollars ($100) per	

Training Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
training materials to the Bureau within ten (10) business days of receipt of the identified change(s) or sooner if there is a scheduled training session that will be impacted.	identified for the training materials, the date the change was identified, and the date the training materials were updated.	days of receipt of the identified change(s).	day after due date.	
Submit a semi-annual training review report to the Bureau for approval.	Contractor shall submit a semi-annual training plan to the Bureau for approval.	Every six (6) months	One hundred dollars ($100) per day after scheduled date.	
Submit an annual detailed Training Plan to the Bureau for approval.	Contractor shall submit a training plan as required.	Within sixty (60) days prior to the calendar year end and within three (3) business days of updating the plan as necessary.	One hundred dollars ($100) per day after scheduled date, unless waived by the Bureau.	

6.1.2.2.3.6.3. 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 must be supported by system hardware and software components, organizational structures, telecommunication links, knowledgeable staff, and readily available accessible databases; all of which must 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 date specified in the report request, or real time, or by 6:00 a.m. CST the	One hundred dollars ($100) per day after scheduled date,	The Contractor may negotiate with requestor if request date or specifications

Reporting Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
		following business day if a batch report request is submitted.		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 noon of the scheduled delivery date, or as directed by the Bureau.	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 will 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	One hundred dollars ($100) per report if not as specified.	

6.1.2.2.3.6.4. Document Management

The Bureau requests that the Facilities Manager 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 Facilities Manager. The solution must 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 workstation. The imaging component should provide the Bureau the capability to access all images captured in the TCMIS.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Document Management related activities.

Document Management Table

Document Management Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
Ensure that all documents are scanned within one (1) business	Contractor shall provide audit information related to scanning processes as	Within one (1) business day of receipt	One hundred dollars ($100) per day per document for	

Document Management Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
day of receipt.	requested by the Bureau, and may be audited to randomly sample documents that were scanned and the date/time when the document was received.		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.	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.	One hundred dollars ($100) per 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 must develop a method for tracking system response time and produce a report with an hourly average by day.	Within a five (5) second average	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 with an accuracy of no less than one hundred percent (100%).	The Contractor shall perform quality assurance on document imaging processes to ensure that the quality meets contractual requirements.	Each day.	One hundred dollars ($100) per occurrence where the accuracy is less than one hundred percent (100%).	

6.1.2.2.3.6.5. Operational Maintenance and Support

The Contractor shall be responsible for maintaining the TCMIS systems and providing operational support, and ensuring that the TCMIS is accessible. Operational support involves all processes necessary to meet the requirements outlined throughout this Contract. The Contractor shall perform all maintenance and support as a routine activity during the Operations Phase at no additional cost to the Bureau. The Contractor shall

provide sufficient technical staff to perform all routine systems maintenance responsibilities. Examples of operational support:

- 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 business analysts, who are the operational and maintenance support personnel for the system, shall be in addition to the staffing necessary for enhancement modifications tasks (see A.4). There will be at least one (1) business analyst identified in this area of responsibility.

The following table lists the operational responsibilities and performance expectations that the Bureau has for the Operational maintenance and support activities.

Operational 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.	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.	Perform research immediately upon recognizing potential system problems in order to minimize system impact, and inform Bureau within five (5) minutes of a potential problem.	Daily monitoring, Notify Bureau within five (5) minutes if problem is identified.	One hundred dollars ($100) per occurrence if problem is discovered and Bureau is not notified timely.	Produce a log report that lists when a system problem was discovered and when corrections actually took place.
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	One hundred dollars ($100) per day per occurrence for each day past the deliverable	

Operational Support Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
			period.	
Proactively maintain and upgrade all software and all Contractor managed 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	One hundred dollars ($100) per occurrence when upgrades are not maintained as required.	
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 should not be allowed to lapse into an unsupported version.	Produce a report that lists the date when upgrades were scheduled and the date when the updates were performed.	When required.	One hundred dollars ($100) per occurrence when upgrades or licenses are not maintained as required.	
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.	One hundred dollars ($100) per occurrence that the transmittals are not used.	

6.1.2.2.3.7. Quality Control

The TCMIS Contractor must 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

6.1.2.2.3.7.1. Quality Control – Integrated Test Facility

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 mirrors production in its files, databases, processing, and reporting. The test facility allows for end-to-end testing, from claims entry through the financial and reporting cycles. All system and integration testing must be performed elsewhere.

The following table lists the operational responsibilities and performance expectations relating to quality control functions.

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.	One hundred dollars ($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.	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 two (2) business days of identification of a defect.	One hundred dollars ($100) per occurrence that the CAP is not received.	
The Contractor shall implement the Bureau-approved corrective action plan within the agreed-upon time frame.	The defect is corrected within the specified timeframe.	Within the agreed-upon time frame.	One hundred dollars ($100) per day that the CAP remedy exceeds the agreed-upon timeframe.	
The Contractor shall correct all deficiencies within the established time frame.	Deficiencies are corrected within timeframes specified.	Within the agreed-upon time frame.	One hundred dollars ($100) per day that deficiencies are not corrected.	
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.	One hundred dollars ($100) per day.	
Contractor shall submit	SDLC documentation is submitted within the	One (1) week prior to	One hundred dollars ($100) per	

Quality Control Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
documentation for each step of the System Development Life Cycle (SDLC). Final system documentation will be submitted for approval one (1) week prior to scheduled implementation.	specified timeframes.	scheduled implementation.	day that the SDLC is late.	

6.1.2.2.3.8. System Availability and Interfaces

The TCMIS System, and all of its subsystems and components, must 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 the 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.	TCMIS disconnections must not be longer than five (5) minutes in a single occurrence. The Bureau or Contract Administrator must be notified when connectivity is restored and System availability is verified.	If TCMIS online connectivity is lost for more than five (5) minutes.	Five hundred dollars ($500) per normal working hour, or any part of a normal working hour thereof, when the network connection is lost. Total damages shall not exceed twenty thousand dollars ($20,000) per week.	The Contractor must notify the Bureau of system unavailability.
Process all interface files (input and output) within specified timeframes according to	The Contractor shall maintain daily control log of outgoing and incoming files.	Each day	One hundred dollars ($100) per day that the SDLC is late.	

System Availability Commitments	Performance Indicators	Deliverable Period	Liquidated Damages	Additional Assessment Criteria
functional area requirements.				
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	One hundred dollars ($100) per occurrence that files are not HIPAA compliant, if due to Contractor issue.	The Contractor shall be responsible for any related damages imposed on the Bureau.

6.1.2.2.3.9. Deliverables

The TCMIS Facilities Manager Contractor is required to submit to the Bureau certain Deliverables during the Transition and Implementation activities, and during the creation and implementation of the system Enhancements. The Liquidated Damages listed in the previous subsections 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 Transition, Implementation and Enhancement activities, requirements and Deliverables contained within the Contract meet the requirements for timeliness and accuracy.

Liquidated Damages imposed on Deliverables are referenced in Deliverables Timeline Table in Section 6.1.2.2.3.9.1. All deliverables will be assessed by timeliness of the deliverable, and accuracy of the deliverable.

A Liquidated damage assessment for timeliness is measured from the expected completion date to the actual completion date, and shall be one hundred dollars ($100) per day after due date, until corrected.

A Liquidated damage for accuracy is 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 5 days), to the date of correction. The liquidated damage assessment for accuracy shall 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	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	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

Deliverable	Liquidated Damages	Additional Assessment Criteria
		corrected report delivery.

6.1.2.2.3.9.1. Deliverables Timeline

Deliverables are expected to be received by close of business on Dates Due.

Expected Timelines for Deliverables are as follows:

Deliverable	Classification	Date Due	Contract Section
	Transition Methodology	2/1/2008	A.2.1
Contractor Comprehension of Project	Transition Methodology	2/1/2008	A.2.1.1.1
Methodology	Transition Methodology	2/1/2008	A.2.1.1.2
Strategy	Transition Methodology	2/1/2008	A.2.1.1.3
	Transition and Implementation Deliverables	1/1/2009	A.2.2
Cost/Benefit Analysis	TCMIS Assessment – Web	3/31/2008	A.2.2.1.1.1
Assessment/Recommendations	TCMIS Assessment – Web	3/31/2008	A.2.2.1.1.2
Web Presentation	TCMIS Assessment – Web	3/31/2008	A.2.2.1.1.3
Change Request Reports	TCMIS Assessment – Change Management	Weekly during Transition	A.2.2.1.2.1
Conduct a review of change management and tracking procedures and provide and assessment and recommendations for processes and tools pertaining to change management and IT governance.	TCMIS Assessment – Change Management	4/1/2008	A.2.2.1.2.2
Cost/Benefit Analysis	TCMIS Assessment – Version Control/Source Code Control	5/1/2008	A.2.2.1.3.1
Assessment/Recommendations	TCMIS Assessment – Version Control/Source Code Control	5/1/2008	A.2.2.1.3.2
Version Control/Source Code Control Presentation	TCMIS Assessment – Version Control/Source Code Control	5/1/2008	A.2.2.1.3.3

Deliverable	Classification	Date Due	Contract Section
Cost/Benefit Analysis	TCMIS Assessment – MITA	6/30/2008	A.2.2.1.4.1
State Self Assessment - 'As-Is' and 'To-Be'	TCMIS Assessment – MITA	6/30/2008	A.2.2.1.4.2
MITA Presentation	TCMIS Assessment – MITA	6/30/2008	A.2.2.1.4.3
Cost/Benefit Analysis	TCMIS Assessment – Recipient and Provider Linking	7/31/2008	A.2.2.1.5.1
Assessment/Recommendations	TCMIS Assessment – Recipient and Provider Linking	7/31/2008	A.2.2.1.5.2
Recipient and Provider Linking Presentation	TCMIS Assessment – Recipient and Provider Linking	7/31/2008	A.2.2.1.5.3
Cost/Benefit Analysis	TCMIS Assessment – MAR Review	7/31/2008	A.2.2.1.6.1
Assessment/Recommendations	TCMIS Assessment – MAR Review	7/31/2008	A.2.2.1.6.2
MAR Review Presentation	TCMIS Assessment – MAR Review	7/31/2008	A.2.2.1.6.3
Cost/Benefit Analysis	TCMIS Assessment – SUR Review	7/31/2008	A.2.2.1.7.1
Assessment/Recommendations	TCMIS Assessment – SUR Review	7/31/2008	A.2.2.1.7.2
SUR Review Presentation	TCMIS Assessment – SUR Review	7/31/2008	A.2.2.1.7.3
Cost/Benefit Analysis	TCMIS Assessment – Mailroom	3/31/2008	A.2.2.1.8.1
Assessment/Recommendations	TCMIS Assessment – Mailroom	3/31/2008	A.2.2.1.8.2
Mailroom Presentation	TCMIS Assessment – Mailroom	3/31/2008	A.2.2.1.8.3
Cost/Benefit Analysis	TCMIS Assessment – TCMIS Performance	8/29/2008	A.2.2.1.9.1
Assessment/Recommendations	TCMIS Assessment – TCMIS Performance	8/29/2008	A.2.2.1.9.2
TCMIS Performance Presentation	TCMIS Assessment – TCMIS Performance	8/29/2008	A.2.2.1.9.3
Cost/Benefit Analysis	TCMIS Assessment – State Software Licenses	6/30/2008	A.2.2.1.10.1
Assessment/Recommendations	TCMIS Assessment – State Software Licenses	6/30/2008	A.2.2.1.10.2
State Software Licenses Presentation	TCMIS Assessment – State Software Licenses	6/30/2008	A.2.2.1.10.3
Cost/Benefit Analysis	TCMIS Assessment – Workflow Management	5/30/2008	A.2.2.1.11.1

Deliverable	Classification	Date Due	Contract Section
Assessment/Recommendations	TCMIS Assessment – Workflow Management	5/30/2008	A.2.2.1.11.2
Workflow Management Presentation	TCMIS Assessment – Workflow Management	5/30/2008	A.2.2.1.11.3
Cost/Benefit Analysis	TCMIS Assessment – Operations Functionality	8/29/2008	A.2.2.1.12.1
Recommendation Paper	TCMIS Assessment – Operations Functionality	8/29/2008	A.2.2.1.12.2
Staff Training and Updating of Operating Procedures	TCMIS Assessment – Operations Functionality	10/31/2008	A.2.2.1.12.3
Operations Functionality Presentation	TCMIS Assessment – Operations Functionality	8/29/2008	A.2.2.1.12.4
Cost/Benefit Analysis	TCMIS Assessment – Oracle Financials	6/30/2008	A.2.2.1.13.1
Recommendation Paper	TCMIS Assessment – Oracle Financials	6/30/2008	A.2.2.1.13.2
Oracles Financials Use Presentation	TCMIS Assessment – Oracle Financials	6/30/2008	A.2.2.1.13.3
Risk Management/Migration Plan	Planning – Risk Management	4/30/2008	A.2.2.2.1.1
Risk Management/Migration Plan Presentation	Planning – Risk Management	4/30/2008	A.2.2.2.1.2
Transition and Implementation Plan	Planning – Transition and Implementation Plan	2/1/2008	A.2.2.2.2.1
Transition and Implementation Plan Presentation	Planning – Transition and Implementation Plan	2/1/2008	A.2.2.2.2.2
Contingency Plan	Planning – Contingency Plan	2/1/2008	A.2.2.2.3.1
Contingency Plan Presentation	Planning – Contingency Plan	2/1/2008	A.2.2.2.3.2
Requirements Analysis, including analysis of current TCMIS operations	Planning – Requirements Analysis/System Design Plan	5/30/2008	A.2.2.2.4.1
Conduct System Design JAD Sessions	Planning – Requirements Analysis/System Design Plan	5/30/2008	A.2.2.2.4.2
System Design Plan Utilizing and ISDM for all TCMIS Systems	Planning – Requirements Analysis/System Design Plan	5/30/2008	A.2.2.2.4.3
System Design Plan utilizing an ISDM for Enhancement functionality into TCMIS	Planning – Requirements Analysis/System Design Plan	5/30/2008	A.2.2.2.4.4

Deliverable	Classification	Date Due	Contract Section
Presentation of Requirements Analysis to Bureau staff	Planning – Requirements Analysis/System Design Plan	5/30/2008	A.2.2.2.4.5
Presentation of System Design Plan to Bureau staff	Planning – Requirements Analysis/System Design Plan	5/30/2008	A.2.2.2.4.6
Transition Staffing Plan	Planning – Transition Staffing Plan	2/1/2008	A.2.2.2.5.1
Transition Staffing Plan Presentation	Planning – Transition Staffing Plan	2/1/2008	A.2.2.2.5.2
Communications Plan	Planning – Communications Plan	2/1/2008	A.2.2.2.6.1
Communications Plan Presentation	Planning – Communications Plan	2/1/2008	A.2.2.2.6.2
Draft Transition and Implementation Project Schedule	Planning – Transition and Implementation Schedule	At Proposal Submission	A.2.2.2.7.1
Completed Transition and Implementation Project Schedule	Planning – Transition and Implementation Schedule	2/1/2008	A.2.2.2.7.2
Informal presentation to the Bureau	Planning – Transition and Implementation Schedule	2/1/2008	A.2.2.2.7.3
Transition and Implementation Work Plan	Planning – Transition and Implementation Work Plan	2/1/2008	A.2.2.2.8.1
Informal presentation to the Bureau	Planning – Transition and Implementation Work Plan	2/1/2008	A.2.2.2.8.2
Configuration Management Plan, which is due no later than 3/31/2008	Planning – Transition and Implementation Work Plan	3/31/2008	A.2.2.2.8.3
The Configuration Management Plan must include a version management strategy	Planning – Transition and Implementation Work Plan	3/31/2008	A.2.2.2.8.4
The Configuration Management Plan must include a build management strategy	Planning – Transition and Implementation Work Plan	3/31/2008	A.2.2.2.8.5
The Configuration Management Plan must include a release management strategy	Planning – Transition and Implementation Work Plan	3/31/2008	A.2.2.2.8.6
The Configuration Management Strategy must include a change management strategy	Planning – Transition and Implementation Work Plan	3/31/2008	A.2.2.2.8.7

Deliverable	Classification	Date Due	Contract Section
Unit Testing Plans and schedule for Transition and Implementation testing	System Testing/Verification/ Validation – System Testing	4/1/2008	A.2.2.3.1.1
Structures Testing Plans and schedule for Transition and Implementation testing	System Testing/Verification/ Validation – System Testing	5/1/2008	A.2.2.3.1.2
User Acceptance Testing Plans and schedule for Transition and Implementation testing	System Testing/Verification/ Validation/ – System Testing	6/2/2008	A.2.2.3.1.3
Present Unit Test results to Bureau	System Testing/Verification/ Validation/ – System Testing	7/1/2008 and twice a month until system takeover operational	A.2.2.3.1.4
Present Structured Test results to Bureau	System Testing/Verification/ Validation/ – System Testing	7/1/2008 and twice a month until system takeover is operational.	A.2.2.3.1.5
Present User Acceptance Test results to Bureau	System Testing/Verification/ Validation/ – System Testing	8/1/2008 and twice a month until system takeover is operational.	A.2.2.3.1.6
Provide IV&V Vendor Project Work Plans	System Testing/Verification/Validation – Independent Verification & Validation	2/1/2008	A.2.2.3.2.2.1
Provide IV&V Vendor Unit Testing Plans and Schedule	System Testing/Verification/Validation – Independent Verification & Validation	4/1/2008	A.2.2.3.2.2.2
Provide IV&V Vendor Structured Testing Plans and Schedule	System Testing/Verification/Validation – Independent Verification & Validation	5/1/2008	A.2.2.3.2.2.3
Provide IV&V Vendor User Acceptance Testing Plans and Schedule	System Testing/Verification/Validation – Independent Verification & Validation	7/1/2008	A.2.2.3.2.2.4
Supply IV&V Vendor Test Results Daily, as Tests are Performed	System Testing/Verification/Validation – Independent Verification & Validation	4/1/2008 and daily as tests are performed	A.2.2.3.2.2.5
Operational Readiness Work Plan	Transition and Implementation Completeness	8/29/2008	A.2.2.4.1
Weekly Reports	Transition and Implementation Completeness	Weekly beginning with Contract start	A.2.2.4.2
Completed Transition and Implementation	Transition and Implementation Completeness	1/1/2009	A.2.2.4.3

Deliverable	Classification	Date Due	Contract Section
Complete TCMIS Infrastructure Documentation as detailed in Section A.5.8 and A.5.9	Transition and Implementation Completeness	11/28/2008	A.2.2.4.4
Formal Presentation to Bureau Staff Outlining the Completed Transition and Implementation Schedule and Work Plan	Transition and Implementation Completeness	8/29/2008	A.2.2.4.5
	Assumption of TCMIS Functions	12/1/2008	A.2.2.5.2
Provide a final operational readiness assessment to assure the ability of the Contractor to operate the TCMIS according to the requirements specified in the Contract.	Assumption of TCMIS Functions	12/1/2008	A.2.2.5.2.1
Conduct training for Bureau staff.	Assumption of TCMIS Functions	12/1/2008	A.2.2.5.2.2
Perform a file reconciliation with current Facilities Manager's records to verify accurateness of all transfer of data after lock-down of related functional area activities, (e.g. eligibility, enrollment, claims, premiums, TPL).	Assumption of TCMIS Functions	12/1/2008	A.2.2.5.2.3
Provide results of file reconciliation to Bureau staff	Assumption of TCMIS Functions	12/15/2008	A.2.2.5.2.4
Transfer all data and files to new FM.	Assumption of TCMIS Functions	12/26/2008	A.2.2.5.2.5
Identify and report any implementation issues to the Bureau, document, place online	Assumption of TCMIS Functions	12/26/2008	A.2.2.5.2.6
Within five (5) days of transfer to new FM, the Bureau, Contractor and outside stakeholders will specify data exchange requirements	Assumption of TCMIS Functions	12/26/2008	A.2.2.5.2.7
Provide issue resolution documentation of outstanding issues	Assumption of TCMIS Functions	12/26/2008	A.2.2.5.8
	Operational Readiness	10/31/2008	A.2.3
Revised Operating Procedures;	Operational Readiness – Contractor Deliverables	10/31/2008	A.2.3.2.1
Training Plan	Operational Readiness – Contractor Deliverables	10/31/2008	A.2.3.2.2
Work Plan	Operational Readiness – Contractor Deliverables	10/31/2008	A.2.3.2.3
Status Reports	Operational Readiness – Contractor Deliverables	10/31/2008	A.2.3.2.4

Deliverable	Classification	Date Due	Contract Section
Report Distribution Schedule	Operational Readiness – Contractor Deliverables	10/31/2008	A.2.3.2.5
Parallel Test Plan and Schedule	Operational Readiness – Contractor Deliverables	10/31/2008	A.2.3.2.6
Operational Test Plan and Schedule	Operational Readiness – Contractor Deliverables	10/31/2008	A.2.3.2.7
Updated Staffing Plan for Operations;	Operational Readiness – Contractor Deliverables	10/31/2008	A.2.3.2.8
Begin Parallel Testing	Operational Readiness – Contractor Deliverables	11/14/2008	A.2.3.2.9
Initial Operational Readiness Assessment and Presentation to the Bureau	Operational Readiness – Contractor Deliverables	11/14/2008	A.2.3.2.10
Final Operational Readiness Assessment and Presentation to the Bureau	Operational Readiness – Contractor Deliverables	12/15/2008	A.2.3.2.11
Conclude Parallel Testing	Operational Readiness – Contractor Deliverables	12/15/2008	A.2.3.2.12
Takeover Implementation of Operations	Operational Readiness – Contractor Deliverables	1/1/2009	A.2.3.2.13
Initial Assessment of Implementation Success and Presentation to the Bureau	Operational Readiness – Contractor Deliverables	1/7/2009	A.2.3.2.14
Assessment of Implementation Success and Presentation to the Bureau	Operational Readiness – Contractor Deliverables	2/2/2009	A.2.3.2.15
	Enhancement Phase Responsibilities	1/1/2009	A.2.9
Enhancement Phase Work Plan and Schedule for each Enhancement, Including Any Updates	Enhancement Phase Responsibilities – Contractor Deliverables	Refer to Due Dates for each Enhancement and coordinate	A.2.9.2.1
Conduct Joint Application Design (JAD) sessions for each Enhancement to make sure the requirements design and analysis supports the Bureau's business processes	Enhancement Phase Responsibilities – Contractor Deliverables	Refer to Due Dates for each Enhancement and coordinate	A.2.9.2.2
Report to Bureau any business process re-engineering needed by either the Bureau or the Facilities Manager for each Enhancement	Enhancement Phase Responsibilities – Contractor Deliverables	Dependent upon schedule of JAD sessions	A.2.9.2.3
Requirements Analysis Documents for each Enhancement	Enhancement Phase Responsibilities – Contractor Deliverables	Refer to Due Dates for each Enhancement and	A.2.9.2.4

Deliverable	Classification	Date Due	Contract Section
		coordinate	
Design Documents for each Enhancement	Enhancement Phase Responsibilities – Contractor Deliverables	Refer to Due Dates for each Enhancement and coordinate	A.2.9.2.5
Each test plan for each test level shall list all test deliverables from that testing level	Enhancement Phase Responsibilities – Contractor Deliverables	Refer to Due Dates for each Enhancement and coordinate	A.2.9.2.6
Testing reports shall be supplied weekly as long as testing is in progress, for a given week and cumulatively to-date	Enhancement Phase Responsibilities – Contractor Deliverables	Refer to Due Dates for each Enhancement and coordinate	A.2.9.2.7
Create System Test Plan, for each Enhancement, including testing responsibilities	Enhancement Phase Responsibilities – Contractor Deliverables	Refer to Due Dates for each Enhancement and coordinate	A.2.9.2.8
Revised system and user documentation incorporating each Enhancement	Enhancement Phase Responsibilities – Contractor Deliverables	Refer to Due Dates for each Enhancement and coordinate	A.2.9.2.9
Perform system testing for each Enhancement	Enhancement Phase Responsibilities – Contractor Deliverables	Refer to Due Dates for each Enhancement and coordinate	A. 2.9.2.10
Create Integrated System Test Plan for each Enhancement	Enhancement Phase Responsibilities – Contractor Deliverables	Refer to Due Dates for each Enhancement and coordinate	A. 2.9.2.11
Perform integrated system testing incorporating each Enhancement	Enhancement Phase Responsibilities – Contractor Deliverables	Refer to Due Dates for each Enhancement and coordinate	A. 2.9.2.12

Deliverable	Classification	Date Due	Contract Section
Distribute integrated system test results for each Enhancement	Enhancement Phase Responsibilities – Contractor Deliverables	Refer to Due Dates for each Enhancement and coordinate	A. 2.9.2.13
Integrated System Test Progress Measurement Metrics for each Enhancement	Enhancement Phase Responsibilities – Contractor Deliverables	Refer to Due Dates for each Enhancement and coordinate	A. 2.9.2.14
Conversion Plan for each Enhancement, if required	Enhancement Phase Responsibilities – Contractor Deliverables	Refer to Due Dates for each Enhancement and coordinate	A.2.9.2.15
Conversion Results for each Enhancement, if required	Enhancement Phase Responsibilities – Contractor Deliverables	Refer to Due Dates for each Enhancement and coordinate	A.2.9.2.16
Problem Log Tracking Plan for each Enhancement	Enhancement Phase Responsibilities – Contractor Deliverables	Refer to Due Dates for each Enhancement and coordinate.	A.2.9.2.17
	TCMIS Enhancement #1 Quality Improvement – CMMI	1/11/2010, CMMI Level 2 1/11/2012 Level 3	A.2.10
Creation of Quality Improvement Units	TCMIS Enhancement #1 – Quality Improvement – CMMI Deliverables	8/1/2008	A.2.10.4.1
Appraisal at CMMI Maturity Level 2	TCMIS Enhancement #1 – Quality Improvement – CMMI Deliverables	1/11/2010	A.2.10.4.2
Appraisal at CMMI Maturity Level 3	TCMIS Enhancement #1 – Quality Improvement – CMMI Deliverables	1/11/2012	A.2.10.4.3
Training Plan	TCMIS Enhancement #1 – Quality Improvement – CMMI Deliverables	4/1/2009	A.2.10.4.4
Project Management Plan	TCMIS Enhancement #1 – Quality Improvement – CMMI Deliverables	4/1/2009	A.2.10.4.5

Deliverable	Classification	Date Due	Contract Section
Communications Plan	TCMIS Enhancement #1 – m Quality Improvement – CMMI Deliverables	4/1/2009	A.2.10.4.6
Process Gap Analysis	TCMIS Enhancement #1 – Quality Improvement – CMMI Deliverables	5/1/2009	A.2.10.4.7
Process Improvement Plan	TCMIS Enhancement #1 – Quality Improvement – CMMI Deliverables	6/1/2009	A.2.10.4.8
Status Reports	TCMIS Enhancement #1 – Quality Improvement – CMMI Deliverables	Monthly starting 8/1/2008	A.2.10.4.9
	TCMIS Enhancement #2 – Claim Check Rules Software	1/1/2009	A.2.11
Procurement of McKesson's ClaimCheck software	TCMIS Enhancement #2 – Claim Check Rules Software – Contractor Deliverables	2/1/2008	A.2.11.4.1
Implementation of McKesson's ClaimCheck software	TCMIS Enhancement #2 – Claim Check Rules Software – Contractor Deliverables	3/3/2008	A.2.11.4.2
Customization for TennCare of McKesson's ClaimCheck software	TCMIS Enhancement #2 – Claim Check Rules Software – Contractor Deliverables	6/2/2008	A.2.11.4.3
Integration with interChange of McKesson's ClaimCheck software	TCMIS Enhancement #2 – Claim Check Rules Software – Contractor Deliverables	6/2/2008	A.2.11.4.4
Detail System Design	TCMIS Enhancement #2 – Claim Check Rules Software – Contractor Deliverables	7/1/2008	A.2.11.4.5
User Manual	TCMIS Enhancement #2 – Claim Check Rules Software – Contractor Deliverables	8/1/2008	A.2.11.4.6
Operations Manual	TCMIS Enhancement #2 – Claim Check Rules Software – Contractor Deliverables	8/1/2008	A.2.11.4.7
Training Manual	TCMIS Enhancement #2 – Claim Check Rules Software – Contractor Deliverables	8/1/2008	A.2.11.4.8
Testing of and Bureau acceptance of McKesson's ClaimCheck Functionality	TCMIS Enhancement #2 – Claim Check Rules Software – Contractor Deliverables	8/1/2008	A.2.11.4.9

Deliverable	Classification	Date Due	Contract Section
Completion and Implementation of Enhancement #2, installation of McKesson's ClaimCheck software	TCMIS Enhancement #2 – Claim Check Rules Software – Contractor Deliverables	1/1/2009	A.2.11.4.10
	TCMIS Enhancement #3 – Project Management Office	6/30/2008	A.2.12
Establish Project Management Office	TCMIS Enhancement #3 – Project Management Office – Contractor PMO Deliverables	3/11/2008	A.2.12.2.1
Develop and Implement Processes to Control Scope of Work	TCMIS Enhancement #3 – Project Management Office – Contractor PMO Deliverables	4/1/2008	A.2.12.2.2
Develop and Implement Other Processes to Oversee the Work Performed	TCMIS Enhancement #3 – Project Management Office – Contractor PMO Deliverables	5/1/2008	A.2.12.2.3
Develop Earned Value Management System (EVMS) Metrics	TCMIS Enhancement #3 – Project Management Office – Contractor PMO Deliverables	5/1/2008	A.2.12.2.4
Develop an Operations Management Plan	TCMIS Enhancement #3 – Project Management Office – Contractor PMO Deliverables	5/1/2008	A.2.12.2.5
Implementation of Project Management Office Operations	TCMIS Enhancement #3 – Project Management Office – Contractor PMO Deliverables	6/30/2008	A.2.12.2.6
Project Charter Documentation	TCMIS Enhancement #3 – Project Management Office – Contractor PMO Deliverables	As Required	A.2.12.2.7
Stakeholder Analysis Documentation	TCMIS Enhancement #3 – Project Management Office – Contractor PMO Deliverables	As Required	A.2.12.2.8
Project Status Reports Documentation	TCMIS Enhancement #3 – Project Management Office – Contractor PMO Deliverables	As Required	A.2.12.2.9
Requirements Analysis Documentation	TCMIS Enhancement #3 – Project Management Office – Contractor PMO Deliverables	As Required	A.2.12.2.10
Business Design Documentation	TCMIS Enhancement #3 – Project Management Office – Contractor PMO Deliverables	As Required	A.2.12.2.11
Technical Design Documentation	TCMIS Enhancement #3 – Project Management Office – Contractor PMO Deliverables	As Required	A.2.12.2.12
	TCMIS Enhancement #4 – COTS Dashboard	1/1/2009	A.2.13
Procurement of Crystal Xcelsius or similar Dashboard COTS Software	TCMIS Enhancement #4 – COTS Dashboard – Contractor Deliverables	3/3/2008	A.2.13.4.1

Deliverable	Classification	Date Due	Contract Section
Implementation of COTS Dashboard Software	TCMIS Enhancement #4 – COTS Dashboard – Contractor Deliverables	4/1/2008	A.2.13.4.2
Customization for TennCare of COTS Dashboard Software	TCMIS Enhancement #4 – COTS Dashboard – Contractor Deliverables	5/1/2008	A.2.13.4.3
Integration with interChange of COTS Dashboard Software	TCMIS Enhancement #4 – COTS Dashboard – Contractor Deliverables	6/2/2008	A.2.13.4.4
Detail Design Document	TCMIS Enhancement #4 – COTS Dashboard – Contractor Deliverables	7/1/2008	A.2.13.4.5
User Manual	TCMIS Enhancement #4 – COTS Dashboard – Contractor Deliverables	8/1/2008	A.2.13.4.6
Operations Manual	TCMIS Enhancement #4 – COTS Dashboard – Contractor Deliverables	8/1/2008	A.2.13.4.7
Training Manual	TCMIS Enhancement #4 – COTS Dashboard – Contractor Deliverables	8/1/2008	A.2.13.4.8
Testing and Bureau acceptance of COTS Dashboard software	TCMIS Enhancement #4 – COTS Dashboard – Contractor Deliverables	10/1/2008	A.2.13.4.9
Completion and Implementation of Enhancement # 4, installation of COTS Dashboard software	TCMIS Enhancement #4 – COTS Dashboard – Contractor Deliverables	1/1/2009	A.2.13.4.10
	TCMIS Enhancement #5 – COTS Documentation Software	12/1/2008	A.2.14
Procurement of Documentation Software	TCMIS Enhancement #5 – COTS Documentation Software – Contractor Deliverables	3/3/2008	A.2.14.4.1
Implementation of Documentation Software	TCMIS Enhancement #5 – COTS Documentation Software – Contractor Deliverables	4/1/2008	A.2.14.4.2
Customization for TennCare of Documentation Software	TCMIS Enhancement #5 – COTS Documentation Software – Contractor Deliverables	5/1/2008	A.2.14.4.3
Integrations with interChange and TeamTrack of Documentation Software	TCMIS Enhancement #5 – COTS Documentation Software – Contractor Deliverables	6/2/2008	A.2.14.4.4

Deliverable	Classification	Date Due	Contract Section
User Manual	TCMIS Enhancement #5 – COTS Documentation Software – Contractor Deliverables	8/1/2008	A.2.14.4.5
Operations Manual	TCMIS Enhancement #5 – COTS Documentation Software – Contractor Deliverables	8/1/2008	A.2.14.4.6
Training Manual	TCMIS Enhancement #5 – COTS Documentation Software – Contractor Deliverables	8/1/2008	A.2.14.4.7
Testing and Bureau acceptance of COTS Documentation software	TCMIS Enhancement #5 – COTS Documentation Software – Contractor Deliverables	10/1/2008	A.2.14.4.8
Completion and Implementation of Enhancement # 5, installation of COTS Documentation software	TCMIS Enhancement #5 – COTS Documentation Software – Contractor Deliverables	12/1/2008	A.2.14.4.9
	TCMIS Enhancement #6 – Enhanced Testing Environment	1/1/2009	A.2.15
Establish Enhanced Test Environment	TCMIS Enhancement #6 – Enhanced Testing Environment – Contractor Deliverables	7/1/2008	A.2.15.4.1
Customize Enhanced Test Environment for TennCare	TCMIS Enhancement #6 – Enhanced Testing Environment – Contractor Deliverables	8/1/2008	A.2.15.4.2
Integration Enhanced Test Environment with interChange	TCMIS Enhancement #6 – Enhanced Testing Environment – Contractor Deliverables	9/1/2008	A.2.15.4.3
Implementation of source code control and version control software in the enhanced test environment	TCMIS Enhancement #6 – Enhanced Testing Environment – Contractor Deliverables	10/1/2008	A.2.15.4.4
Receipt and acceptance of output produced from the multiple test environments	TCMIS Enhancement #6 – Enhanced Testing Environment – Contractor Deliverables	11/1/2008	A.2.15.4.5
Verification of Bureau online access to the multiple testing environments	TCMIS Enhancement #6 – Enhanced Testing Environment – Contractor Deliverables	11/3/2008	A.2.15.4.6

Deliverable	Classification	Date Due	Contract Section
Receipt and acceptance of control reports	TCMIS Enhancement #6 – Enhanced Testing Environment – Contractor Deliverables	10/1/2008	A.2.15.4.7
Receipt and acceptance of test data	TCMIS Enhancement #6 – Enhanced Testing Environment – Contractor Deliverables	11/3/2008	A.2.15.4.8
Receipt and acceptance of Test Plans (Test Management & System Test)	TCMIS Enhancement #6 – Enhanced Testing Environment – Contractor Deliverables	11/3/2008	A.2.15.4.9
Receipt and acceptance of Unit Test Plans	TCMIS Enhancement #6 – Enhanced Testing Environment – Contractor Deliverables	11/3/2008	A.2.15.4.10
Receipt and acceptance of Integration Test Plans	TCMIS Enhancement #6 – Enhanced Testing Environment – Contractor Deliverables	11/3/2008	A.2.15.4.11
Bureau acceptance and approval of testing of all four (4) testing environments	TCMIS Enhancement #6 – Enhanced Testing Environment – Contractor Deliverables	12/1/2008	A.2.15.4.12
Completion and Implementation of Enhanced Testing Environment	TCMIS Enhancement #6 – Enhanced Testing Environment – Contractor Deliverables	1/1/2009	A.2.15.4.13
Convert the current Model Office environment to a full systems test environment	TCMIS Enhancement #6 – Enhanced Testing Environment – Contractor Deliverables	12/1/2008	A.2.15.4.14
Convert the current UAT environment to a regression test environment	TCMIS Enhancement #6 – Enhanced Testing Environment – Contractor Deliverables	12/1/2008	A.2.15.4.15
	TCMIS Enhancement #7 – Business Process Modeling	6/30/2009	A.2.16
Establish Business Process Modeling Unit	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	6/30/2008	A.2.16.4.1
Overall Project Strategy	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	7/31/2008	A.2.16.4.2

Deliverable	Classification	Date Due	Contract Section
Procurement of Business Process Modeling Software	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	7/31/2008	A.2.16.4.3
Bureau acceptance and approval of methodology and Activity Based Costing	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	8/29/2008	A.2.16.4.4
Assessment of Mailroom activities	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	9/30/2008	A.2.16.4.5
Assessment of electronic filing and imaging abilities	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	9/30/2008	A.2.16.4.6
Assessment of existing information systems	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	10/31/2008	A.2.16.4.7
Comprehensive, detailed analysis of Bureau of TennCare's business processes	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	4/30/2009	A.2.16.4.8
Comprehensive, detailed analysis of Facilities Manager's business processes	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	2/27/2009	A.2.16.4.9
Bureau acceptance and approval of Contractor's assessment of mailroom activities	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	10/31/2008	A.2.16.4.10
Bureau acceptance and approval of Contractor's assessment of the electronic filing and imaging abilities	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	10/31/2008	A.2.16.4.11
Bureau acceptance and approval of Contractor's assessment of existing information system	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	11/28/2008	A.2.16.4.12
Bureau acceptance and approval of Contractor's comprehensive, detailed analysis of Bureau of TennCare's business processes	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	5/29/2009	A.2.16.4.13
Bureau acceptance and approval of Contractor's comprehensive, detailed analysis of Facilities Manager business processes	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	3/31/2009	A.2.16.4.14

Deliverable	Classification	Date Due	Contract Section
Quality assurance review process	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	5/29/2009	A.2.16.4.15
Internet utilization evaluation and recommendations	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	4/30/2009	A.2.16.4.16
Cost-benefit recommendations relating to each analysis and assessment	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	5/29/2009	A.2.16.4.17
Completion of Enhancement #7 and outline procedures for maintaining Business Process Modeling	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	6/30/2009	A.2.16.4.18
Provide a thorough Activity Based Costing analysis with each assessment and recommendation.	TCMIS Enhancement #7 – Business Process Modeling – Contractor Deliverables	Varies with Deliverable	A.2.16.4.19
	TCMIS MMIS Certification	1/1/2009	A.5.2
Bureau approval of TCMIS systems documentation;	TCMIS MMIS Certification – Contractor Certification Deliverables	3/1/2009	A.5.2.4.1
Completion of the online source code library with updated versions of all previous materials and new material previously missing;	TCMIS MMIS Certification – Contractor Certification Deliverables	3/1/2009	A.5.2.4.2
Review final certification documents;	TCMIS MMIS Certification – Contractor Certification Deliverables	3/1/2009	A.5.2.4.3
Federal certification of the TCMIS;	TCMIS MMIS Certification – Contractor Certification Deliverables	9/30/2009	A.5.2.4.4
Contractor demonstrations that TCMIS financial data and claims inventory counts are being verified through routine balancing procedures;	TCMIS MMIS Certification – Contractor Certification Deliverables	3/1/2009	A.5.2.4.5
Contractor demonstrations that all TCMIS claim types are being processed at production volumes and within timeliness of claims processing requirements, as defined in part 6.1.2.2.3.3 of Attachment 2 of the Contract.	TCMIS MMIS Certification – Contractor Certification Deliverables	3/1/2009	A.5.2.4.6

Deliverable	Classification	Date Due	Contract Section
Contractor demonstrations that system reports are being delivered to Bureau users according to the performance requirements, as defined in part 6.1.2.2.3.6.3 of Attachment 2 of the Contract.	TCMIS MMIS Certification – Contractor Certification Deliverables	3/1/2009	A.5.2.4.7
	Business Continuity and Contingency Plan (BCCP)	11/3/2008	A.5.4
Submit to the Bureau the BCCP at least sixty (60) days prior to assumption of FM operations.	Business Continuity and Contingency Plan (BCCP) Deliverable	11/3/2008	A.5.4.3.1
Submit a Security Plan within thirty (30) calendar days of Contract signing, and update annually thereafter.	Business Continuity and Contingency Plan (BCCP) Deliverable	Within thirty (30) calendar days of Contract signing	A.5.4.3.2
	Quality Assurance/Quality Improvement	5/1/2008	A.5.5
Quality Assurance/Quality Improvement (QA/QI) Plan	Quality Assurance/Quality Improvement – Contractor Quality Assurance Deliverables	3/3/2008	A.5.5.3.1
SCR Reduction Plan	Quality Assurance/Quality Improvement – Contractor Quality Assurance Deliverables	4/1/2008	A.5.5.3.2
Sample Test Plan	Quality Assurance/Quality Improvement – Contractor Quality Assurance Deliverables	5/1/2008	A.5.5.3.3
	TCMIS Infrastructure Documentation Deliverables	12/1/2008	A.5.9
The Contractor shall provide documentation software as detailed under Section A.2.14, Enhancement #5.	TCMIS Infrastructure Documentation Deliverables	12/1/2008	A.5.9.1.1
The Contractor is responsible for demonstrating that all operational software and related materials, as well as all proprietary products used in TCMIS operations, are working as expected within thirty (30) business days prior to the Contractor's assumption of FM Operations.	TCMIS Infrastructure Documentation Deliverables	12/1/2008	A.5.9.1.2

Deliverable	Classification	Date Due	Contract Section
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 must be complete and presented to the Bureau within thirty (30) days prior to the Contractor’s assumption of FM Operations.	TCMIS Infrastructure Documentation Deliverables	12/1/2008	A.5.9.1.3
The Contractor shall be responsible for the production and distribution of all updated copies (hard and soft), of the TCMIS infrastructure documentation to ensure that they are current, and shall be responsible for maintaining and updating each of the Bureau’s copies.	TCMIS Infrastructure Documentation Deliverables	12/1/2008	A.5.9.1.4
Hardcopies of documentation must use 8 ½” x 11” pages in three (3) ring binder form, with pages numbered within each section, and a revision date on each page. Revisions must be clearly identified and revision summary pages.	TCMIS Infrastructure Documentation Deliverables	12/1/2008	A.5.9.1.5
The Contractor shall maintain the online version of the documentation, updating each component as ongoing updates to the TCMIS require.	TCMIS Infrastructure Documentation Deliverables	12/1/2008	A.5.9.1.6
The Contractor shall deliver all materials and information needed for Certification review.	TCMIS Infrastructure Documentation Deliverables	TBD	A.5.9.1.7
	Turnover Deliverables	1/1/2010 and One (1) year prior to end of Contract	A.5.6.9.1
Turnover Approach	Turnover Deliverables	1/1/2010	A.5.6.9.1.1
TCMIS Requirements Statement	Turnover Deliverables	1/1/2010	A.5.6.9.1.2

Deliverable	Classification	Date Due	Contract Section
Resource Inventory, including staff, hardware and software that is needed to operate all aspects of the TCMIS	Turnover Deliverables	1/1/2010	A.5.6.9.1.3
TCMIS Software and Files	Turnover Deliverables	1/1/2010	A.5.6.9.1.4
Up-to-Date TCMIS System, User, Operations, Procedures and Training Documentation	Turnover Deliverables	1/1/2010	A.5.6.9.1.5
Turnover Deliverables (e.g. progress reports, inventories, configuration diagrams)	Turnover Deliverables	1/1/2010	A.5.6.9.1.6

6.1.2.2.4. Dashboard Performance Metrics Reporting and Supporting Documentation

All information used to calculate the performance metrics should be stored in tables or databases and accessed via the dashboard software required in the TCMIS enhancement listed in section A.2.13. Supporting documentation must be maintained by the Contractor for all performance metric calculations. The supporting documentation for any performance metric must be delivered to the Bureau within two (2) business days after it is requested.

6.1.3. Attachment 3

6.1.3.1. HIPAA Business Associate Agreement (BAA)

HIPAA BUSINESS ASSOCIATE AGREEMENT (BAA)

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

_____located at_____

_____ ("Business Associate"), 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.

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

LIST OF AGREEMENTS AFFECTED BY THIS HIPAA BUSINESS ASSOCIATE AGREEMENT	**Execution Date**
Please check if not applicable ☐	

In the course of executing Service requests, 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, 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.

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

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

1.6 "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.

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

1.8 "Individual" shall have the same meaning as the term "individual" in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

1.9 "Marketing" means the act or process of promoting, selling, leasing or licensing any information or data for profit without the express written permission of Covered Entity.

1.10 "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.

1.11 "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.

1.12 "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 164.501, 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.

1.13 "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.501.

1.14 "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.

1.15 “Security Event” shall mean an immediately reportable subset of security incidents which incident would include:

d) 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;

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

f) 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

g) 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.

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

2.4 Mitigation of Harmful Effect of Violations. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

2.5 Reporting of Violations in Use and Disclosure of PHI. Business Associate agrees to require its employees, agents, and subcontractors to promptly report to Business Associate any use or disclosure of PHI in violation of this Agreement and to report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement. The Business Associate shall report such violation to Covered Entity within two (2) business days of such time as it completes its initial review of the incident but not less than five (5) business days of the time it became aware of the incident.

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 and notify the Covered Entity of such action within two (2) business days of completion of the request. If Business Associate receives a request for PHI in the possession of the Covered Entity, or receives a request to exercise other individual rights as set forth in the Privacy Rule, Business Associate shall promptly forward the request to Covered Entity within two (2) business days. 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 within two (2) business days 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 within two (2) business days, 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) 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 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.

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

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

3.2 Security Safeguards and Policies. Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the covered entity as required by the Security Rule. This includes specifically, but is not limited to, the utilization of technology commercially available at the time to the Business Associate to protect the Covered Entity's PHI against any reasonably anticipated threats or hazards. The Business Associate understands that it has an affirmative duty to perform a regular review or assessment of security risks, conduct active risk management and supply best efforts to

assure that only authorized persons and devices access its computing systems and information storage, and that only authorized transactions are allowed. The Business Associate will maintain appropriate documentation of its compliance with the Security Rule.

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

3.4 Tennessee Consumer Notice of System Breach. Business Associate understands that the Covered Entity is an "information holder" (as may be Business Associate) under the terms of Tenn. Code Ann. § 47-18-2107, and that in the event of a breach of the Business Associate's security system as defined by that statute and Definition 1.2 of this agreement, the Business Associate shall indemnify and hold the Covered Entity harmless for expenses and/or damages related to the breach. Such obligation shall include, but is not limited to, the mailed notification to any Tennessee resident whose personal information is reasonably believed to have been acquired by an unauthorized individual. In the event that the Business Associate discovers circumstances requiring notification of more than one thousand (1,000) persons at one time, the person shall also notify, without unreasonable delay, all consumer reporting agencies and credit bureaus that compile and maintain files on consumers on a nationwide basis, as defined by 15 U.S.C. § 1681a, of the timing, distribution and content of the notices. Substitute notice, as defined by Tenn. Code Ann. § 47-18-2107(e)(2) and (3), shall not be permitted except as approved in writing in advance by the Covered Entity. The parties agree that PHI includes data elements in addition to those included by "personal information" under Tenn. Code Ann.

§ 47-18-2107, and agree that Business Associate's responsibilities under this paragraph shall include all PHI.

3.5 Reporting of Security Incidents. The Business Associate shall track all security incidents as defined by HIPAA and shall periodically report such security incidents in summary fashion as may be requested by the Covered Entity, but not less than annually within sixty (60) days of the anniversary of this Agreement. The Covered Entity shall not consider as security incidents, for the purpose of reporting, external activities (port enumeration, etc.) typically associated with the "footprinting" of a computing environment as long as such activities have only identified but not compromised the logical network perimeter, including but not limited to externally facing firewalls and web servers. The Business Associate shall reasonably use its own vulnerability assessment of damage potential and monitoring to define levels of Security Incidents and responses for Business Associate's operations. However, the Business Associate shall expediently notify the Covered Entity's Privacy Officer of any Security Incident which would constitute a Security Event as defined by this Agreement, including any "breach of the security of the system" under Tenn Code Ann. § 47-18-2107, within two (2) business days. The Business Associate shall likewise notify the Covered Entity within two (2) business days of any unauthorized acquisition including but not limited to use, disclosure, modification, or destruction of PHI by an employee or otherwise authorized user of its system of which it becomes aware.

3.5.1 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 3.4 and 3.5 shall be in writing made by certified mail or overnight parcel within two (2) business days after 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.

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 42 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 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.

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, except for those related to Sections 3.4 and 3.5 of this Agreement, 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.

COVERED ENTITY:	BUSINESS ASSOCIATE:
Darin J. Gordon	**[Name]** _____
Deputy Commissioner	**[Title]** _____
Department of Finance and Adm. Bureau of TennCare	**[Entity]** _____
310 Great Circle Road	**[Address]**_____
Nashville, TN 37243	_____
(615) 507-6443	**[Telephone]** _____
Fax: (615) 253-5607	**Fax:** _____

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

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

8.8 Severability. With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to

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

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

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

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

BUREAU OF TENNCARE	**[BUSINESS ASSOCIATE]**
By: _____	By:_____
Date:_____	Date:_____
Darin J. Gordon, Deputy Commissioner	***[name & title]***
State of Tennessee, Dept of Finance & Adm.	[entity name]
310 Great Circle Road	[Address]
Nashville, Tennessee	[Address]
(615) 507-6443	[Phone]
(615) 253-5607	[Fax]

6.1.4. Attachment 4

6.1.4.1. 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 of TennCare.

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. 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 US 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. 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 recipients 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 current FM and the Bureau of TennCare

BA: Business Services Analyst.

BAA: Business Associate Agreement (in conjunction with HIPAA Privacy and Security Rules).

BCBS: Blue Cross/Blue Shield.

BCCP: Business Continuity and Contingency Plan.

BCWP: Budgeted Cost of Work Performed.

BCWS: Budgeted Cost of Work Scheduled.

BENDEX: Beneficiary Data Exchange System - Federal government information regarding persons receiving SSA benefits.

BENEFITS: A schedule of covered health care services that an eligible participant 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).

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: Commerce and Insurance.

CAP: Corrective Action Plan.

CAPITATION PAYMENT: Monthly payments made to Managed Care Contractors for providing services to TennCare members.

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 75% percent 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 75% FFP is authorized for the Administrative costs of an MMIS.

CFR: Code of Federal Regulations.

CHA: Community health agencies.

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 new 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, which is not from a provider under investigation for possible fraud and noncompliance, and does not require additional information.

CLIA: Clinical Laboratory Improvement Amendments.

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 titled: 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 interChange.

CONTRACT: The written, signed agreement resulting from this RFP.

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 under the RFP.

CONTRACTOR: The term Contractor refers to the successful Proposer with whom the State has successfully negotiated a Contract.

CONTRACTUAL TERMS IN RFP: The use of the terms “shall,” “must,” and “will” refers to a mandatory requirement or condition to be met by the Contractor.

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.

CSR: Customer Service Representative.

CST: Central Standard Time

CTS: Computerized Telephony System.

CVO: Centralized Verification Organization.

DANIEL’S 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: 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: 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: Department of Mental Health and Developmental Disability, used interchangeably with **MHDD.**

DMRS: Department of Mental Retardation Services.

DOC: Department of Corrections.

DOD: United States Department of Defense.

DOH: 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. EDS is the current Facilities Manager for the TennCare program.

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.

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: State of 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 life 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.

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. 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, 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 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: 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 judge.

LAN: Local Area Network.

LSU: 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 claim rule & 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: 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.

NOTICE OF INTENT TO PROPOSE: Notification to Bureau of TennCare of Contractor's forthcoming proposal to RFP.

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: Office of Contract Compliance and Performance.

OCR: Office of Contract Review.

OCR: Optical Character Recognition.

OGC: Office of General Counsel.

OIG: 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 Reports.

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.

PASARR: 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 100% of the Federal Poverty Level and are considered uninsured or uninsurable.

PRO: Peer Review Organization.

PROCUREMENT LIBRARY: TCMIS items for review by 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.

PROPOSER: Any corporation, company or organization that submits a response to this RFP.

PROVIDER: Entity that provides services (e.g. medical, mental health, dental, 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 an MCC or the Bureau reviews and renders a decision regarding an enrollee’s appeal for the MCCs adverse action affecting TennCare benefits. This could include the reconsideration claims, 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.

RESPONSE PROPOSAL: Any proposal submitted in response to this RFP.

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.

RFP COORDINATOR: The State official who has the responsibility for being the main point of contact for this RFP.

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, just for Medical Eligibility (ME).

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 (children).

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 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 (2).

SOLQ: Social Security Online Query file.

SPMI: Severely and Persistently Mentally Ill enrollees (adults).

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: 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 of TennCare to perform services for the Bureau of TennCare.

SUR: Surveillance and Utilization Review.

SURS: Surveillance and Utilization Review Subsystem.

TAD: Turnaround Document. Long term care Level I 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.

TCIS: TennCare Information Systems, referenced as an entity of the Bureau's management of the TCMIS.

TCIS: TennCare Information System.

TCMIS: TennCare Management Information System.

TDHS: Tennessee Department of Human Services, also referred to as DHS.

TDM: Technical Delivery Manager.

TDMR: Tennessee Department 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 an 1115 waiver.

TENNCARE LAWSUITS: There are three (3) lawsuits that have an 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: Tennessee 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.

VA: 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.

WP: Work Planner.

WR: Work Request - A maintenance request for the TCMIS, non-billable.

WORK REQUEST: A maintenance request for the TCMIS, non-billable.

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.

6.2. PROPOSAL TRANSMITTAL AND STATEMENT OF CERTIFICATIONS AND ASSURANCES

PROPOSAL TRANSMITTAL AND STATEMENT OF CERTIFICATIONS AND ASSURANCES **The Proposer must complete and sign this Proposal Transmittal and Statement of Certifications and Assurances. It must be signed, in the space below, by an individual empowered to bind the proposing entity to the provisions of this RFP and any Contract awarded pursuant to it. If said individual is not the Proposer's chief executive or president, this document shall attach evidence showing the individual's authority to bind the proposing entity.** **Any contract resulting from this RFP process shall incorporate this Proposal Transmittal and Statement of Certifications and Assurances by reference as a part of said contract (refer to pro forma contract "Special Terms and Conditions").**	
PROPOSER LEGAL ENTITY NAME:	
PROPOSER FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	
The Proposer does hereby affirm and expressly declare confirmation, certification, and assurance of the following: 1) This proposal constitutes a commitment to provide all services as defined in the RFP Attachment 6.1, *Pro Forma* Contract Scope of Services for the total contract period and confirmation that the Proposer shall comply with all of the provisions in this RFP and shall accept all terms and conditions set out in the RFP Attachment 6.1, *Pro Forma* Contract. 2) The information detailed in the proposal submitted herewith in response to the subject RFP is accurate. 3) The proposal submitted herewith in response to the subject RFP shall remain valid for at least 120 days subsequent to the date of the Cost Proposal opening and thereafter in accordance with any contract pursuant to the RFP. 4) The Proposers shall comply with: a) the laws of the State of Tennessee; b) Title VI of the federal Civil Rights Act of 1964; c) Title IX of the federal Education Amendments Act of 1972; d) the Equal Employment Opportunity Act and the regulations issued there under by the federal government; e) the Americans with Disabilities Act of 1990 and the regulations issued there under by the federal government; f) the condition that the submitted proposal was independently arrived at, without collusion, under penalty of perjury; and, g) the condition that no amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Proposer in connection with the Procurement under this RFP. 5) The Proposer shall provide a performance bond in accordance with the requirements of the RFP.	
SIGNATURE & DATE:	

6.3. TECHNICAL PROPOSAL AND EVALUATION GUIDE

TECHNICAL PROPOSAL & EVALUATION GUIDE — SECTION A		
PROPOSER NAME:		
SECTION A — MANDATORY REQUIREMENTS		
The Proposer must address ALL Mandatory Requirements section items and provide, in sequence, the information and documentation as required (referenced with the associated item references). The RFP Coordinator will review all general mandatory requirements, including, but not limited to, the following: • **Proposal received on or before the Proposal Deadline.** • **Technical Proposal copies and Cost Proposal packaged separately.** • **Technical Proposal contains NO cost data.** • **Proposer did NOT submit alternate proposals.** • **Proposer did NOT submit multiple proposals in a different form.** • **Technical Proposal does NOT contain any restrictions of the rights of the State or other qualification of the proposal.** **The RFP Coordinator will also review the proposal to determine if the Mandatory Requirement Items (below) are met and mark each with pass or fail. For each requirement that is not met, the Proposal Evaluation Team must review the proposal and attach a written determination.** **Any contract resulting from this RFP process shall incorporate by reference the respective proposal responses to all items below as a part of said contract (refer to *pro forma* contract "Special Terms and Conditions").** **NOTICE: In addition to these requirements, the State will also evaluate compliance with ALL RFP requirements.**		
Proposal Page # (to be completed by Proposer)	**Mandatory Requirement Items**	**State Use ONLY** **Pass/Fail**
	A.1 Provide the Proposal Transmittal and Statement of Certifications and Assurances (detailed in RFP Attachment 6.2) completed and signed, in the space provided, by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract. **Each Proposer *must* sign the Proposal Transmittal and Statement of Certifications and Assurances without exception or qualification.**	
	A.2 Provide the following as documentation of financial responsibility and stability: • a current written bank reference, in the form of a standard business letter, indicating that the proposer's business relationship with the financial institution is in positive standing, • two (2) current written, positive credit references, in the form of standard business letters, from vendors with which the Proposer has done business or, documentation of a positive credit rating determined by an accredited credit bureau within the last six (6) months; • a copy of a valid certificate of insurance indicating liability insurance in the amount of at least Five Million dollars ($5,000,000);	

	• a letter of commitment from a financial institution (signed by an authorized agent of the financial institution and detailing the proposer's name) for a general line of credit in the amount of Five Hundred Thousand Dollars ($500,000.00).	
	A.3 Provide a statement of whether the Proposer, or any individual who shall perform work under the contract, has a possible conflict of interest (e.g. employment by the State of Tennessee) and, if so, the nature of that conflict. **Any questions of conflict of interest shall be solely within the discretion of the State, and the State reserves the right to cancel any award.**	
	A.4 The proposal must provide the name, mailing address, and telephone number of the person the State should contact regarding the proposal.	
	A.5 The proposal must state whether the proposer intends to use subcontractors - if so, clearly identify the names of the subcontractors along with complete mailing addresses and the scope and portions of the work the subcontractors shall perform.	
	A.6 The proposal must describe the proposer's form of business (e.g. individual, sole proprietor, corporation, non-profit corporation, partnership, joint venture, limited liability company, et cetera)	
	A.7 If the proposer is a joint venture, the proposal must also provide: information that clearly details the respective responsibilities and functions that each principal of the joint venture or partnering entities would perform if awarded a contract pursuant to the RFP; and a copy of the joint venture or partnering agreements that identify the principals involved as well as their rights and responsibilities regarding a contract pursuant to the RFP.	
	A.8 Provide evidence that the proposer has completed, as the primary provider of implementation services, a takeover of a Medicaid Management Information System (MMIS). As evidence of meeting this requirement, proposer will complete a table listing all clients of the proposer that meet the above criteria, with the name of the entity, budget, number of clients, the dates of the engagement, services provided by the proposer, the engagement status as of RFP submission (e.g. complete, in progress), the products implemented and the modules/ functionality within those products that were deployed.	

	A.9 The Proposal must indicate if the solution utilizes all State standard software and hardware products, non-State standard products approved prior to submission of the Proposal, or non-State standard products not approved prior to submission of the Proposal. a) If the solution utilizes all State standard software, no additional response is needed. b) If the solution utilizes non-State standard product(s) for which exception request(s) were submitted to the State as Written Question(s) by any vendor, no additional response is needed. c) If the exception request for the non-standard product was approved, the Proposal will not be disqualified for utilizing the product. d) If the exception request was not approved, the Proposal may be disqualified for utilizing the product. e) If the solution utilizes non-State standard products for which an exception request was not submitted to the State as a Written Question, the Proposal must include one (1) of the following: 1. a statement confirming that the vendor will replace the non-State standard product with an equivalent State standard product, prior to implementation, with no increase in proposed cost. If the vendor does not agree to do this, the Proposal will be disqualified. Or: 2. a statement that there is no equivalent State standard product, along with the supporting documentation for the product. In this case, the State reserves the right to consider the proposed software on a case-by-case basis. The decision to allow or disallow such software shall be at the State's sole discretion; if the State decides to disallow the software, the State may disqualify the Proposal.	

TECHNICAL PROPOSAL & EVALUATION GUIDE — SECTION B	
PROPOSER NAME:	
SECTION B — QUALIFICATIONS & EXPERIENCE	
The Proposer must address ALL Qualifications and Experience section items and provide, in sequence, the information and documentation as required (referenced with the associated item references). **A Proposal Evaluation Team, made up of three (3) or more State employees, will independently evaluate and score the proposal's "qualifications and experience" responses.** **Any contract resulting from this RFP process shall incorporate by reference the respective proposal responses to all items below as a part of said contract (refer to *pro forma* contract "Special Terms and Conditions").**	
Proposal Page # (to be completed by Proposer)	**Qualifications & Experience Items**
	B.1 Describe the Proposer's form of business (e.g. individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the name, mailing address, and telephone number of the person the State should contact regarding the proposal.
	B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of the Proposer company within the last ten (10) years, and if so, an explanation providing relevant details.
	B.3 Provide a statement of whether the Proposer or any of the Proposer's employees, agents, independent contractors, or subcontractors have been convicted of, pled guilty to, or pled nolo contendere to any felony, and if so, an explanation providing relevant details.
	B.4 Provide a statement of whether there is any pending litigation against the Proposer; and if such litigation exists, an attached opinion of counsel as to whether the pending litigation will impair the Proposer's performance in a Contract under this Contract.
	B.5 Provide a statement of whether, in the last ten (10) years, the Proposer has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors, and if so, an explanation providing relevant details.
	B.6 Provide a statement of whether there are any pending Securities Exchange Commission investigations involving the Proposer, and if such are pending or in progress, an explanation providing relevant details and an attached opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract under this RFP.
	B.7 Provide a brief, descriptive statement indicating the Proposer's credentials to deliver the services sought under this RFP.
	B.8 Briefly describe how long the Proposer has been performing the services required by this RFP and include the number of years in business.
	B.9 Describe the Proposer organization's number of employees, client base, and location of offices.
	B.10 Provide a narrative description of the proposed project team, its members, and organizational structure.
	B.11 Provide a personnel roster and resumes of key people who shall be assigned by the Proposer to perform duties or services under the contract (include estimated number of hours to be worked on the contract for each person, and the resumes shall detail each individual's title, education, current position with

	the Proposer, and employment history) as well as an organizational chart highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrating the lines of authority and designate the individual responsible for the completion of each service component and deliverable of the RFP. The following Proposer roles will be considered key personnel for this project: • Account Manager. Account Manager. • Project Management Office (PMO) Director. • Operations Project Managers(s). • Operations Processing Manager. • Computer Operations Manager. • TCMIS Systems Manager. • Enhancement Project Manager. • Database Administrator. • Transition Project Manager. • Transition Deputy Project Manager. The State expects that all of these key personnel will be dedicated full-time to the project. Proposer may not propose any one (1) person to fill more than one (1) key position listed above. a) Provide in a table format the following information for these key personnel, and for any other Proposer personnel that the Proposer wishes to present as part of its response: • Name; • Title; • Role (specific work to be performed); • Brief description (seventy-five (75) words or less) of qualifications and relevant experience that makes the proposed individual suitable for his/her designated role on this project; • Estimated number of hours by State fiscal year under the Contract; and, • The individual's employment status (employee, contractor, etc.) and tenure with proposing firm. • Provide detailed professional resumes for all staff members presented above. b) All Proposer personnel assigned to this project will be subject to the States' approval, including those submitted as part of the proposal. Upon their approval by the State, the State and the Proposer will agree to designate as key personnel the specific members of the project team who are in the roles listed above. Specific conditions and requirements will apply to key personnel as stated in Section A.6. of RFP Attachment 6.1, *Pro Forma* Contract. Note: A Personnel Resume Format Is included as Attachment 6.3.1.
	B.12 Provide a statement of whether the Proposer intends to use subcontractors, and if so, the names and mailing addresses of the committed subcontractors and a description of the scope and portions of the work the subcontractors will

	perform.
	B.13 Provide documentation of Proposer commitment to diversity as represented by its business strategy, business relationships, and workforce — this documentation should detail: • a description of the Proposer's existing programs and procedures designed to encourage and foster commerce with business enterprises owned by minorities, women, persons with a disability and small business enterprises; • a listing of the Proposer's current contracts with business enterprises owned by minorities, women, persons with a disability and small business enterprises, including the following information: o contract description and total value; o contractor name and ownership characteristics (e.g. ethnicity, sex, disability); o contractor contact and telephone number; • an estimate of the level of participation by business enterprises owned by minorities, women, persons with a disability and small business enterprises in a contract awarded to the Proposer pursuant to this RFP, including the following information: o participation estimate (expressed as a percent of the total contract value that will be dedicated to business with subcontractors and supply contractors having such ownership characteristics); o descriptions of anticipated contracts; o names and ownership characteristics (e.g. ethnicity, sex, disability) of anticipated subcontractors and supply contractors anticipated; • the percent of the Proposer's total current employees by ethnicity, sex, and disability. **Proposers that demonstrate a commitment to diversity will advance State efforts to expand opportunity to do business with the State as contractors and subcontractors. Proposal evaluations will recognize the positive qualifications and experience of a Proposer that does business with enterprises owned by minorities, women, persons with a disability and small business enterprises and that offers a diverse workforce to meet service needs.**
	B.14 Provide customer reference for similar projects representing both three (3) of the larger accounts currently serviced by the vendor and three (3) completed projects, as well as a list, if any, of all current contracts with the State of Tennessee and all those completed within the previous five (5) year period. Each reference must include: • the company name and business address; • the name, title, and telephone number of the company contact knowledgeable about the project work; and • a brief description of the service provided and the period of service. The list of contracts with the State of Tennessee must include: • the contract number; • the contract term; and • the procuring state agency for each reference. **Each evaluator will generally consider the results of reference inquiries by the State regarding all references provided (both State and non-State). Current or prior contracts with the State are not a prerequisite and are not required for the maximum evaluation score possible, and the existence of such contracts with the State will not automatically**

	result in the addition or deduction of evaluation points.
	B.15 Provide a narrative description of the recommended project and business process organization. Present an updated proposed organization chart for the implementation team, showing the Proposer's recommended project organization and including all of the recommended Proposer roles. Provide a table showing all roles (Proposer, State or subcontractor) proposed for the engagement with a brief description of the responsibilities and the recommended staffing level and expected source of personnel for each listed role. In addition to the narrative for this section, Proposer must complete a schedule using the format in section A.6.2.2. The schedule must present the Proposers staffing plan for Maintenance and User Support Staff. Note that these schedules are requesting estimates in numbers of FTEs only. Do not include any cost or pricing information on these schedules.
	B.16 Provide explanation(s) pertaining to projects that were not implemented within the original project timelines for all similar projects that were completed within the previous five (5) year period.

(Maximum Section B Score = 30)	
SCORE (for all Section B items above, B.1 through B.16):	

TECHNICAL PROPOSAL & EVALUATION GUIDE — SECTION C					
PROPOSER NAME:					
SECTION C — TECHNICAL APPROACH					
The Proposer must address ALL Technical Approach section items and provide, in sequence, the information and documentation as required (referenced with the associated item references). A Proposal Evaluation Team, made up of three (3) or more State employees, will independently evaluate and score the proposal's response to each item. Each evaluator will use the following whole number, raw point scale for scoring each item:					
0 = little value	**1 = poor**	**2 = fair**	**3 = satisfactory**	**4 = good**	**5 = excellent**
The RFP Coordinator will multiply each item score by the assigned weight with the product being the item's raw weighted score for purposes of calculating the section score as detailed at the end of this table. **Any contract resulting from this RFP process shall incorporate by reference the respective proposal responses to all items below as a part of said contract (refer to *pro forma* contract "Special Terms and Conditions").**					

Proposal Page # (to be completed by Proposer)	**Technical Approach Items**		**State Use ONLY**		
			Score	**Item Weight**	**Raw Weighted Score**
	C.1	Provide a narrative that illustrates the Proposer's understanding of the State's requirements and project schedule.		5	
	C.2	Provide a narrative that illustrates how the Proposer will complete the scope of services, accomplish required objectives, and meet the State's project schedule.		5	
	C.3	Provide a narrative that illustrates how the Proposer will manage the project, ensure completion of the scope of services, and accomplish required objectives within the State's project schedule.		5	
	C.4	Provide a narrative that illustrates the Proposer's understanding of the Current and Future TennCare Initiatives and the associated requirements (Section 6.10).		2	
	C.5	Provide a narrative that illustrates the Proposer's understanding of the TCMIS Takeover and Enhancement Project Management requirements (A.1).		5	
	C.6	Provide a narrative that illustrates the Proposer's understanding of the TCMIS Takeover transition, transition assessments, and operational readiness requirements and a transition Work Plan that demonstrates the Proposer's understanding of the transition timeline and work effort (A.2.1, A.2.2, &, A.2.3).		10	
	C.7	Provide a narrative that illustrates the Proposer's understanding of the general requirements pertaining to the Enhancements to the TCMIS (A.2.4 through A.2.9).		6	
	C.8	Provide a narrative that illustrates the		3	

		Proposer's understanding of the CMMI enhancement (A.2.10).			
	C.9	Provide a narrative that illustrates the Proposer's understanding of the Claim Check enhancement (A.2.11)		2	
	C.10	Provide a narrative that illustrates the Proposer's understanding of the Project Management Office enhancement (A.2.12)		6	
	C.11	Provide a narrative that illustrates the Proposer's understanding of the COTS Dashboard enhancement (A.2.13)		2	
	C.12	Provide a narrative that illustrates the Proposer's understanding of the COTS Documentation software enhancement (A.2.14)		3	
	C.13	Provide a narrative that illustrates the Proposer's understanding of the Test Environment enhancement (A.2.15)		6	
	C.14	Provide a narrative that illustrates the Proposer's understanding of the Business Process Documentation enhancement (A.2.16)		6	
	C.15	Provide a narrative that illustrates the Proposer's understanding of the MITA initiative and self-assessment objective. (A.2.2.1.4).		2	
	C.16	Provide a narrative that illustrates the Proposer's understanding of the Facilities Manager Business processes and Function Requirements (A.3).		17	
	C.17	Provide a narrative that illustrates the Proposer's understanding of the TennCare Change Management Requirements (A.4).		4	
	C.18	Provide a narrative that illustrates the Proposer's understanding of the TennCare General Facilities Management Requirements (A.5).		6	
	C.19	Provide a narrative that illustrates the Proposer's understanding of the TennCare Facilities Management Staffing Requirements (A.6).		5	
		Total Raw Weighted Score: (sum of Raw Weighted Scores above)			

	Total Raw Weighted Score 500 maximum possible raw weighted score (e.g. 5 x the sum of item weights above)	X 40 (maximum section score)	= SCORE:

6.3.1. Personnel Resume Format

A. PERSONAL INFORMATION

Individual's Name

Proposed Position

Education

Background

B. WORK EXPERIENCE

Individual's Experience with the Following (If Applicable):

Project management and issue tracking

Information technology planning and strategy

Management of IT outsourcing and procurement processes

Large scale system analysis, design, development and testing

Large scale production systems operations

Medicare and Medicaid programs

MMIS, MITA and Medicaid technology

Commercial health plan systems and processes

Eligibility and enrollment

Claims and encounter processing, HIPAA transactions and code sets

Provider credentialing and provider data

Health care financial and utilization data reporting and analysis

IT staffing and organizational design Definition of policies and procedures Development and delivery of training curricula Technical writing

Capacity planning and evaluation

C. EMPLOYMENT HISTORY

Employed from_____to_____

Employer's Name

Job Title

Project 1:

Client's Name (if different from Employer's)

Project Name

Project Start and End Date (include percent of time allotted to the project)

Description of Project

Individual's Job Title (include length of time position held)

Individual's Project Duties and Responsibilities

Repeat C for as many jobs and projects as needed.

6.4. COST PROPOSAL AND SCORING GUIDE

This RFP is issued for the transition and implementation of the TCMIS and related existing systems.

Contractors must submit a separate Pricing Schedule in response to each item listed in the pricing schedules. Contractors may not choose to submit a Bid Proposal for parts of the scope of work as identified within this RFP.

6.4.1. Pricing Schedule A– Transition and Implementation Pricing Detail

Using Pricing Schedule A found on the following page, Contractors will present a pricing detail of the fixed costs for Transition and Implementation Phases for the takeover of the current system.

The successful Contractor will be paid “per deliverable” during the Transition and Implementation Phase of the Contract. The successful Contractor will be paid in accordance with the proposed fixed prices for each deliverable set forth in the Contract. The total of all “per deliverable” prices will equal the proposed Transition Phase Total Fixed Price shown as the Grand Total in the Pricing Schedule A. Total Transition and Implementation Fixed Price will already factor in all related costs and overhead (e.g., Salaries & Benefits, Travel, and Administrative Overhead)

Pricing Schedule A

Transition and Implementation Pricing Detail

Item #	Line Item Description	Fixed Price
1	Assessment 1 – Web Assessment Section A.2.2.1.1	$
2	Assessment 2 – Change Management Assessment Section A.2.2.1.2	$
3	Assessment 3 – Version Control / Source Code Control Assessment Section A.2.2.1.3	$
4	Assessment 4 – MITA Assessment Section A.2.2.1.4	$
5	Assessment 5 – Recipient and Provider Linking Assessment Section A.2.2.1.5	$
6	Assessment 6 – MAR Review Section A.2.2.1.6	$
7	Assessment 7 – SUR Review Section A.2.2.1.7	$
8	Assessment 8 – Mailroom Business Process Assessment Section A.2.2.1.8	$
9	Assessment 9 – TCMIS Performance Assessment Section A.2.2.1.9	$
10	Assessment 10 – State Software Licenses Assessment Section A.2.2.1.10	$
11	Assessment 11 – Work Flow Management Assessment Section A.2.2.1.11	$
12	Assessment 12 – Operations Functionality Section A.2.2.1.12	$
13	Assessment 13 – Oracle Financials Section A.2.2.1.13	$
	GRAND TOTAL	$

Transition Phase – To endorse impartiality between the incumbent Contractor and any new Contractor interested in this re-procurement, the Bureau will reimburse the Contractor up to fifteen percent (15%) of the annual average fixed cost of the Operations

Base Rate, (Refer to 6.4.3 Pricing Schedule C1 – Operations Costs – Base Rate). The Bureau will reimburse the Contractor for actual costs for any transition related infrastructure costs which will no longer be incurred during the operating phase of the contract (including office space and related costs, (e.g. hardware, software licenses)) required for any Non-Assessment transition tasks or Non-Enhancement tasks up to fifteen percent (15%) of the annual average fixed cost of the Operations Base Rate, (Refer to C.3.3 Pricing Schedule C1 – Operations Costs – Base Rate). Invoices and supporting documentation for these transition payments can be submitted to the Bureau the later of January 1, 2009, or the start of operations (e.g. after successful completion of the TCMIS takeover by the Contractor).

To obtain reimbursement of actual additional costs, the Contractor must submit sufficient supporting documentation to obtain Bureau approval for reimbursement of actual additional costs.

6.4.2. Pricing Schedule B – Pricing of Major System Enhancements

Pricing Schedule B provides a template for the pricing of the "TCMIS System Enhancements" shown in Contract Sections A.2.10 through A.2.16. Contractors for the TCMIS Contract are expected to show a total cost for the enhancements, as well as a description and itemized cost for the elemental components that build up into the proposed cost. TennCare has provided some examples in line item categories for Enhancements, but the Contractors may identify additional line item categories. If the cost associated with the enhancement requires COTS software or software licenses, the Contractor will enter Software Costs Associated with the TCMIS Enhancements in the detailed breakdown of any costs that have been listed in 6.4.2 Pricing Schedule B.

Pricing Schedule B

Pricing of TCMIS System Enhancements

Item #	Line Item Description	*Fixed Price
Ex	Example Enhancement (Contract Section XX)	
	Example: Salary & Benefits	$400,000
	Example: Software and License Costs	$500,000
	Total Enhancement Example	$900,000
E1	CMMI Level 2 Appraisal (Contract Section A.2.10)	
		$
		$
	Total Enhancement #1	$
E1.1	CMMI Level 3 Appraisal (Contract Section A.2.10)	
		$
		$
	Total Enhancement #1.1	$
E2	Implement the ClaimCheck (Contract Section A.2.11)	
		$
		$
	Total Enhancement #2	$

Item #	Line Item Description	*Fixed Price
E3	Implement PMO (Contract Section A.2.12)	
		$
		$
	Total Enhancement #3	$
E4	Implement a COTS Dashboard (Contract Section A.2.13)	
		$
		$
	Total Enhancement #4	$
E5	Develop or provide a COTS Documentation software (Contract Section A.2.14)	
		$
		$
	Total Enhancement #5	$
E6	Implement Enhanced Test Environment (Contract Section A.2.15)	
		$
		$
	Total Enhancement #6	$
E7	Detailed documentation of all TennCare business processes (Contract Section A.2.16)	
		$
		$
	Total Enhancement #7	$

* Refer to Section C.3 for Payment Methodology.

6.4.3. Pricing Schedule C– Operations Costs (TCMIS)

Pricing Schedule C provides a template to show the Contractor's proposed operations costs. Contractors for the TCMIS Contract are expected to provide a base rate on a "fixed cost" basis. Pricing Schedule C1, Item #1 should indicate the proposed base rate for operations of the TCMIS, excluding enhancements. Pricing Schedule C2, Item #1 should indicate the proposed incentive fixed cost. The proposed incentive fixed cost for each year is calculated by multiplying the operations base rate for each year by 15%. For example, if the proposer bids $100 for year 1 operational base rate (Price Schedule C1), the proposer should enter fifteen dollars ($15) as the year 1 incentive rate (Price Schedule C2). The incentive payment will be paid based on the Contractor receiving a Quality and Customer Service score greater than or equal to eighty-six (86). However, the Contractor will only receive a fifty percent (50%) incentive payment for scores between eighty-six (86) and ninety-three (93).

Some of the enhancements that were priced in 6.4.2 Pricing Schedule B may have ongoing operational costs in addition to the implementation costs. Items E1 – E7 of Pricing Schedule C3 on the following pages, should indicate the proposed rates, if any, for the ongoing operational costs that can be expected for each of the enhancements. For each enhancement line item that has an entry for ongoing operational costs, the Contractors must provide the cost detail and justification for the additional "fixed cost" fee.

Pricing Schedule C1

Operations Costs – Base Rate (TCMIS)

		Fixed Cost				
Item #	Line Item Description	Operational Year 1 (1/1/2009 – 12/31/2009)	Operational Year 2 (1/1/2010 – 12/31/2010)	Operational Year 3 (1/1/2011 – 12/31/2011)	Operational Year 4 (1/1/2012 – 12/31/2012)	Average
1	Base Rate	$	$	$	$	$

Pricing Schedule C2

Operations Costs – Incentive Rate (TCMIS)

		Fixed Cost				
Item #	Line Item Description	Operational Year 1 (1/1/2009 – 12/31/2009)	Operational Year 2 (1/1/2010 – 12/31/2010)	Operational Year 3 (1/1/2011 – 12/31/2011)	Operational Year 4 (1/1/2012 – 12/31/2012)	Average
1	Incentive Rate	$	$	$	$	$

Pricing Schedule C3

Operations Costs – Enhancement Operations (TCMIS)

		Fixed Cost				
Item #	Line Item Description	Operational Year 1 (1/1/2009 – 12/31/2009)	Operational Year 2 (1/1/2010 – 12/31/2010)	Operational Year 3 (1/1/2011 – 12/31/2011)	Operational Year 4 (1/1/2012 – 12/31/2012)	Average
E1	Operations costs associated with maintaining CMMI Level 2 Appraisal	$	$	$	$	$
E1.1	Operations costs associated with maintaining CMMI Level 3 Appraisal	$	$	$	$	$
E2	Operations costs associated with ClaimCheck	$	$	$	$	$
E3	Operations costs associated with PMO	$	$	$	$	$
E4	Operations costs associated with the COTS Dashboard	$	$	$	$	$
E5	Operations costs associated with the COTS Documentation software	$	$	$	$	$
E6	Operations costs associated with the Enhanced Test Environment	$	$	$	$	$

		Fixed Cost				
Item #	Line Item Description	Operational Year 1 (1/1/2009 – 12/31/2009)	Operational Year 2 (1/1/2010 – 12/31/2010)	Operational Year 3 (1/1/2011 – 12/31/2011)	Operational Year 4 (1/1/2012 – 12/31/2012)	Average
E7	Operations costs associated with maintaining the TennCare process documentation, including system and change and process model integration	$	$	$	$	$
	Grand Total for Pricing Schedule C3	$	$	$	$	$

6.4.4. Pricing Schedule D

6.4.4.1. Pricing Schedule D1

Excess Staffing

Excess Staffing (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 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.

CATEGORY	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE
	1/11/2008 — 12/31/2008	01/01/2009 — 12/31/2009	01/01/2010 — 12/31/2010	01/01/2011 — 12/31/2011	01/01/2012 — 12/31/2012
Information Specialist - Senior	$	$	$	$	$
Information Specialist	$	$	$	$	$
Information Analyst	$	$	$	$	$
Information Associate	$	$	$	$	$
Business Services Analyst - Senior	$	$	$	$	$
Business Services Analyst - Advanced	$	$	$	$	$
Business Services Analyst	$	$	$	$	$
Technical Delivery Team Manager	$	$	$	$	$
Project Manager	$	$	$	$	$
Project Analyst - Senior	$	$	$	$	$
Project Analyst - Advanced	$	$	$	$	$

CATEGORY	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE	HOURLY RATE
	1/11/2008 — 12/31/2008	01/01/2009 — 12/31/2009	01/01/2010 — 12/31/2010	01/01/2011 — 12/31/2011	01/01/2012 — 12/31/2012
Project Analyst	$	$	$	$	$
Data Base Administrator	$	$	$	$	$
Data Base Associate	$	$	$	$	$
Infrastructure Specialist Senior	$	$	$	$	$
Systems Administrator - -Advanced	$	$	$	$	$
Systems Administrator	$	$	$	$	$
Systems Administrator - Associate	$	$	$	$	$
Computer Operator	$	$	$	$	$
QA Specialist - Advanced	$	$	$	$	$
QA Specialist	$	$	$	$	$
Documentation Manager	$	$	$	$	$
Technical Writer	$	$	$	$	$
Specialized Support Clerk	$	$	$	$	$
General Support Clerk	$	$	$	$	$
Change Management Coordinator	$	$	$	$	$
Release Coordinator	$	$	$	$	$
Work Planner	$	$	$	$	$

Excess Staffing – Total Amount for the Cost Proposal Scoring Guide

The table is used by the Proposer to calculate the total amount to be entered in the Cost Proposal Scoring Guide.

CATEGORY	**Estimated Excess Staffing Hours**	**Multiply Hourly Rate above by Estimated Excess Staffing Hours**	**Multiply Hourly Rate above by Estimated Excess Staffing Hours**	**Multiply Hourly Rate above by Estimated Excess Staffing Hours**	**Multiply Hourly Rate above by Estimated Excess Staffing Hours**	**Multiply Hourly Rate above by Estimated Excess Staffing Hours**
	Each Year	01/11/2008 — 12/31/2008	01/01/2009 — 12/31/2009	01/01/2010 — 12/31/2010	01/01/2011 — 12/31/2011	01/01/2012 — 12/31/2012
Information Specialist - Senior	6,000 hrs	$	$	$	$	$
Information Specialist	7,500 hrs	$	$	$	$	$
Information Analyst	6,500 hrs	$	$	$	$	$
Information Associate	2,500 hrs	$	$	$	$	$
Business Services Analyst - Senior	5,000 hrs	$	$	$	$	$
Business Services Analyst - Advanced	5,000 hrs	$	$	$	$	$
Business Services Analyst	5,000 hrs	$	$	$	$	$
Technical Delivery Team Manager	3,500 hrs	$	$	$	$	$
Project Manager	3,500 hrs	$	$	$	$	$
Project Analyst - Senior	3,500 hrs	$	$	$	$	$
Project Analyst - Advanced	2,500 hrs	$	$	$	$	$
Project Analyst	500 hrs	$	$	$	$	$
Data Base	1,000 hrs	$	$	$	$	$

CATEGORY	Estimated Excess Staffing Hours	Multiply Hourly Rate above by Estimated Excess Staffing Hours	Multiply Hourly Rate above by Estimated Excess Staffing Hours	Multiply Hourly Rate above by Estimated Excess Staffing Hours	Multiply Hourly Rate above by Estimated Excess Staffing Hours	Multiply Hourly Rate above by Estimated Excess Staffing Hours
	Each Year	01/11/2008 — 12/31/2008	01/01/2009 — 12/31/2009	01/01/2010 — 12/31/2010	01/01/2011 — 12/31/2011	01/01/2012 — 12/31/2012
Administrator						
Data Base Associate	1,000 hrs	$	$	$	$	$
Infrastructure Specialist Senior	500 hrs	$	$	$	$	$
Systems Administrator - - Advanced	1,000 hrs	$	$	$	$	$
Systems Administrator	500 hrs	$	$	$	$	$
Systems Administrator - Associate	500 hrs	$	$	$	$	$
Computer Operator	500 hrs	$	$	$	$	$
QA Specialist - Advanced	1,500 hrs	$	$	$	$	$
QA Specialist	1,500 hrs	$	$	$	$	$
Documentation Manager	1,500 hrs	$	$	$	$	$
Technical Writer	2,500 hrs	$	$	$	$	$
Specialized Support Clerk	1,500 hrs	$	$	$	$	$
General Support Clerk	1,500 hrs	$	$	$	$	$
Change Management Coordinator	500 hrs	$	$	$	$	$

CATEGORY	**Estimated Excess Staffing Hours**	**Multiply Hourly Rate above by Estimated Excess Staffing Hours**	**Multiply Hourly Rate above by Estimated Excess Staffing Hours**	**Multiply Hourly Rate above by Estimated Excess Staffing Hours**	**Multiply Hourly Rate above by Estimated Excess Staffing Hours**	**Multiply Hourly Rate above by Estimated Excess Staffing Hours**
	Each Year	01/11/2008 — 12/31/2008	01/01/2009 — 12/31/2009	01/01/2010 — 12/31/2010	01/01/2011 — 12/31/2011	01/01/2012 — 12/31/2012
Release Coordinator	500 hrs	$	$	$	$	$
Work Planner	500 hrs	$	$	$	$	$
Grand Total		$	$	$	$	$

6.4.4.2. **Pricing Schedule D2**

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 thresholds, as authorized by the Bureau. Each threshold will be treated independently with no compensation or deduction for volumes that fall below the threshold. The Contractor shall submit invoices no more often than quarterly (invoices for excess ballots shall be submitted annually), 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**			
	01/01/2009 – 12/31/2009	01/01/2010 – 12/31/2010	01/01/2011 – 12/31/2011	01/01/2012 – 12/31/2012
Suspense Transactions	$	$	$	$
Letters	$	$	$	$
Ballots	$	$	$	$

Note: Excess Suspense Transactions is defined as suspended claims needing resolution activities.

Excess Letters is defined as those that are generated for special mailings.

Excess Ballots is defined as those that are generated and mailed more than annually.

Excess Operations Transaction – Total Amount for the Cost Proposal Scoring Guide

The table below is used by the Proposer to calculate the total amount to be entered in the Cost Proposal Scoring Guide.

TRANSACTION TYPE	**Estimated Excess Transactions**	**Multiply Fixed Fee above by the Estimated Excess Transactions**	**Multiply Fixed Fee above by the Estimated Excess Transactions**	**Multiply Fixed Fee above by the Estimated Excess Transactions**	**Multiply Fixed Fee above by the Estimated Excess Transactions**
	Each Year	01/01/2009 – 12/31/2009	01/01/2010 – 12/31/2010	01/01/2011 – 12/31/2011	01/01/2012 – 12/31/2012
Suspense Transactions	20,000	$	$	$	$
Letters	400,000	$	$	$	$
Ballots	1,500,000	$	$	$	$
Grand Total		$	$	$	$

Cost Proposal Scoring Guide

COST PROPOSAL SCORING GUIDE	
NOTICE TO PROPOSER: This Cost Proposal MUST be completed EXACTLY as required.	
PROPOSER NAME:	
SIGNATURE & DATE:	
NOTE: The signatory must be an individual or a company officer empowered to contractually bind the Proposer. If the Signatory is not the Proposer's chief executive or president, this Statement of Certifications and Assurances SHALL attach evidence showing the Signatory's authority to bind the Proposer.	

COST PROPOSAL SCHEDULE

The proposed cost, detailed below, shall indicate the proposed price for providing the entire scope of service including all services as defined in the RFP Attachment 6.1, Pro Forma Contract Scope of Services for the total contract period. The proposed cost and the submitted technical proposal associated with this cost shall remain valid for at least one hundred twenty (120) days subsequent to the date of the Cost Proposal opening and thereafter in accordance with any resulting Contract between the Proposer and the State. All monetary amounts are United States currency.

Cost Item Description	**Proposed Cost**					**State Use ONLY**
	One-time Service or Implementation	**Operations Year 1**	**Operations Year 2**	**Operations Year 3**	**Operations Year 4**	**Total Cost Amount (Sum Proposed Cost)**
Transition and Implementation (Enter Grand Total from Pricing Schedule A in the One-time Service or Implementation)	$	$	$	$	$	
Enhancement 1 (Enter Total from Pricing Schedule B in the One-time Service or Implementation)	$	$	$	$	$	
Enhancement 1.1 (Enter Total from Pricing Schedule B in the One-time Service or Implementation)	$	$	$	$	$	

Cost Item Description	One-time Service or Implementation	Operations Year 1	Operations Year 2	Operations Year 3	Operations Year 4	Amount (Sum Proposed Cost)
Enhancement 2 (Enter Total from Pricing Schedule B in the One-time Service or Implementation)	$	$	$	$	$	
Enhancement 3 (Enter Total from Pricing Schedule B in the One-time Service or Implementation)	$	$	$	$	$	
Enhancement 4 (Enter Total from Pricing Schedule B in the One-time Service or Implementation)	$	$	$	$	$	
Enhancement 5 (Enter Total from Pricing Schedule B in the One-time Service or Implementation)	$	$	$	$	$	
Enhancement 6 (Enter Total from Pricing Schedule B in the One-time Service or Implementation)	$	$	$	$	$	
Enhancement 7 (Enter Total from Pricing Schedule B in the One-time Service or Implementation)	$	$	$	$	$	
Base Operations (Enter Total from Pricing Schedule C1 for Operations Years 1 through 4)	$	$	$	$	$	
Operations Incentive (Enter Total from Pricing Schedule C2 for Operations Years 1 through 4)	$	$	$	$	$	

Cost Item Description	One-time Service or Implementation	Operations Year 1	Operations Year 2	Operations Year 3	Operations Year 4	Amount (Sum Proposed Cost)
Operations Enhancements (Enter Grand Total from Pricing Schedule C3 for Operations Years 1 through 4)	$	$	$	$	$	
Excess Staffing (Enter Grand Total from Pricing Schedule D1 in the One-time Service or Implementation for the first grand total column and in the Operations Years 1 through 4 for all other columns)	$	$	$	$	$	
Excess Transactions (Enter Grand Total from Pricing Schedule D2 in the One-time Service or Implementation for the first grand total column and in the Operations Years 1 through 4 for all other columns)	$	$	$	$	$	
The RFP Coordinator shall use the evaluation cost amount derived from the proposed cost amounts above and the following formula to calculate the COST PROPOSAL SCORE. Calculations shall result in numbers rounded to two (2) decimal places.				**Evaluation Cost Amount:** (sum of all total cost amounts above)		

	Lowest Evaluation Cost Amount from all Proposals / **Evaluation Cost Amount Being Evaluated**	**X 30** (maximum section score)	**= [Cost Proposal SCORE]**

6.5. PROPOSAL SCORE SUMMARY MATRIX

Attachment 6.5 Proposal Score Summary Matrix

PROPOSAL SCORE SUMMARY MATRIX

RFP Coordinator			**Date**			
QUALIFICATIONS & EXPERIENCE **Maximum Points: 30**	**PROPOSER NAME**		**PROPOSER NAME**		**PROPOSER NAME**	
EVALUATOR NAME						
EVALUATOR NAME						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE SCORE:		**AVERAGE SCORE:**		**AVERAGE SCORE:**	
TECHNICAL APPROACH **Maximum Points: 40**						
EVALUATOR NAME						
EVALUATOR NAME						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE SCORE:		**AVERAGE SCORE:**		**AVERAGE SCORE:**	
COST PROPOSAL **Maximum Points: 30**	**SCORE:**		**SCORE:**		**SCORE:**	
PROPOSAL SCORE Maximum Points: 100	**TOTAL SCORE:**		**TOTAL SCORE:**		**TOTAL SCORE:**	

6.6. SAMPLE PERFORMANCE BOND

ATTACHMENT 6.6

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).
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)
to complete Work detailed in the Scope of Services detailed in the State of Tennessee Request for Proposals bearing the RFP Number:

RFP NUMBER 318.65-211
a copy of which said Request for Proposals and the resulting Contract are by reference hereby made a part hereof, as fully and to the same extent as if copied at length herein.
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 subcontractor 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.
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)

6.7. EVALUATION NOTICE

STATE OF TENNESSEE

BUREAU OF TENNCARE

310 GREAT CIRCLE ROAD

NASHVILLE, TENNESSEE 37243

[DATE]

[NAME]

[COMPANY NAME]

[STREET ADDRESS]

[CITY, STATE, ZIP]

Dear [NAME],

Thank you for your proposal in response to RFP number 318.65-211. The State has completed its evaluation of proposals in response to this Request for Proposals, and the subject procurement records are open for public inspection.

[NAME OF APPARENT BEST EVALUATED PROPOSER] is the apparent best evaluated Proposer that the State will consider for Contract award. This notice is NOT an acceptance of any offer, and the State retains the right to reject any proposal.

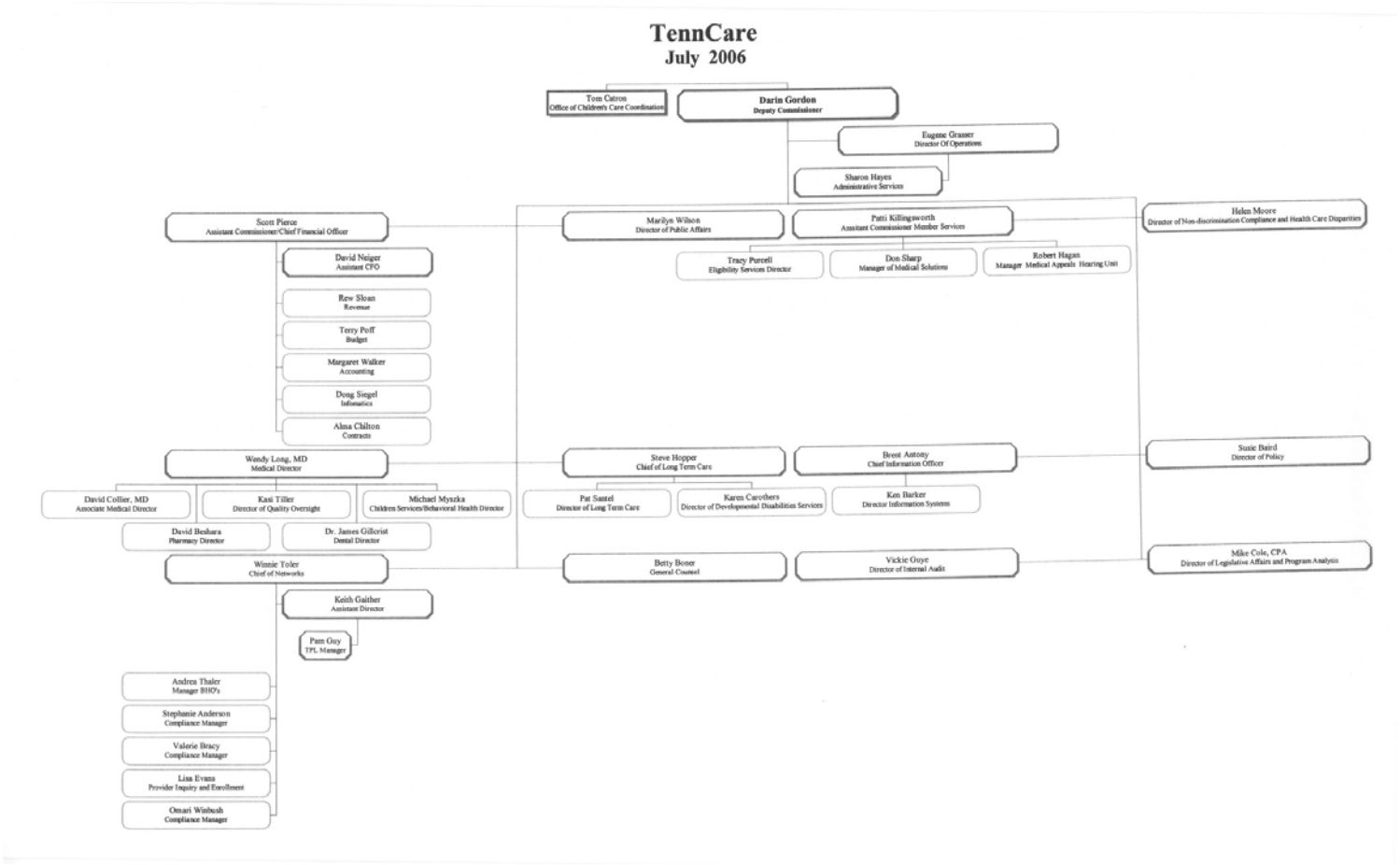
In accordance with the subject Contract and State law, this notice shall NOT create rights, interests, or claims of entitlement in the apparent best evaluated Proposer or any vendor. No vendor shall acquire any such right unless and until a Contract is fully signed by all appropriate State officials.

We appreciate your interest in providing services to the State of Tennessee and hope that you will respond to future Requests for Proposals.

Sincerely,

[AGENCY HEAD SIGNATURE]

6.8. ORGANIZATION CHART



6.9. PROCUREMENT LIBRARY

A procurement library will be located at:

Department of Finance and Administration
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243

Review dates will begin September 19, 2007 and will conclude October 10, 2007, weekends and State holidays excluded. Review time will be during normal State working hours, 8:00 a.m. through 4:30 p.m. Central Standard Time. Review time must be reserved three (3) working days in advance. Reservations can be made by contacting:

Alma Chilton, Phone number (615) 507-6384.

Reservations can be made by calling for an appointment. A copier will be made available for the reviewer to make copies at fifteen (15) cents per page. Only checks made out to the State of Tennessee will be accepted.

A DVD of materials in the Procurement Library will be made available upon request for official Proposers. The DVD can be requested through the same phone number listed above.

The attempt has been made to include as much relevant data as possible in the Procurement Library. Efforts have been made to provide information that is complete and current. However, the Bureau of TennCare does not warrant that the information is complete or current and disclaims any liability as a result of reliance by a Proposer upon library contents for the preparation of a response proposal. Items included in the Procurement Library are:

- RFP and Proposal for the DHS Vision Integration Platform (VIP) implementation

  VIP RFP website http://www.tennessee.gov/humanserv/vip-rfp.htm

- Copy of RFP and Proposal for Edison (ERP) project

  Edison intranet sites:

  Computer skills training;
  http://intranet.state.tn.us/finance/oir/training/edison.html

  Other information; http://intranet.state.tn.us/erp

- Copy of TennCare Waiver:

  http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp

- General Medicaid Rules
- TeamTrack information and Training Manuals
- Standards Guidelines and Technical Architecture

  State website
  http://www.intranet.state.tn.us/finance/oir/qa/stds/arch/architecture-current.pdf

- Hardware/Software Product Standards
- Software renewal spreadsheet

- Information Technology Methodology Model (ITM) - State website http://www.intranet.state.tn.us/finance/oir/SDS/itm/WebPage/WebSite/ITMhome.htm
- Eligibility Categories – State website: http://www.state.tn.us/tenncare/mem-categories.html
- Prioritized inventory listing of all active SCRs and WRs
- Managed Care Organizations: http://www.state.tn.us/tenncare/pro-mcos.html
- Current Facilities Manager Turnover Plan
- Copy of Information Systems Plans: http://www.state.tn.us/finance/oir/prd/stplan.pdf
- Part 11 of the State Medicaid Manual http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS021927&intNumPerPage=10
- Service Level Agreements http://intranet.state.tn.us/finance/oir/cos/sla_list.html
- Project Workbook Homepage http://pwb.tenncare.nash.tenn/tennessee/Default.asp
- Standard Product list
- External Interfaces
- Current System Documentation (including All DSDs, User Manuals, and Operations Manuals)
- interChange Data Model
- All TCMIS Extract Layouts
- Software licensure repository with required additional copies as directed by the Bureau
- Operating Systems capacities
- Processing Data Volumes
- interChange Source Code and corresponding documentation
- Windows Source Code and corresponding documentation
- Web Source code and corresponding documentation
- AS400 Source code and corresponding documentation
- Bureau of TennCare Organization chart updated July 2007

6.10. CURRENT AND FUTURE INITIATIVES AND TCMIS OVERVIEW

6.10.1. Current and Future Initiatives

Several State and federally mandated initiatives, which will require changes to the Bureau of TennCare's System Management and Business Process Management services, face the TennCare enterprise. These initiatives offer a set of challenges to the Bureau's management and staff.

6.10.1.1. DHS's Eligibility VIP Implementation

The current TennCare Management Information System (TCMIS) interfaces with the Tennessee Department of Human Services (DHS) ACCENT System, which has multiple eligibility files and is used to process TennCare eligibility. DHS is in the process of implementing a replacement to the ACCENT System. The DHS replacement system - Vision Integration Platform (VIP) - is being designed to create a single interface file to be sent to the TCMIS. The Facilities Management Contractor must make all appropriate changes for the TCMIS interface with VIP. The TCMIS will need to process the new eligibility file, which will require a redesign of the eligibility interface, some modifications to interChange eligibility processing, and significant parallel testing activities. The modifications and testing for this initiative are not included in this Contract Proposal. A separate Work Order will be issued at the appropriate time to achieve this system modification.

The overall impact on the TCMIS applications is not known at this time. The largest and most significant impact to the TCMIS will be modifications to the eligibility interfaces and changes to application logic to accommodate the VIP. The start of the design phase of this project is imminent. The impact of this project will begin in FY07 for design activities and will continue with design, development, testing and implementation tasks. A relatively high level of complex customization was done to the interChange eligibility/enrollment processes during the original implementation. The VIP implementation project will most likely require extensive design, development and testing to ensure a successful implementation. The possible utilization of Health Insurance Portability and Accountability Act (HIPAA)-compliant transaction standardization between both applications (VIP and interChange) may present additional challenges to the development and implementation of the VIP interface.

Additional information can be found in the DHS RFP and Proposal for the VIP.

6.10.1.2. Project Edison – Enterprise Resource Planning (ERP) Solution

The Tennessee Department of Personnel, Department of Finance and Administration, Department of General Services, Department of Transportation, and the Department of the Treasury have agreed that the State's current administrative systems can be significantly improved with the implementation of an Enterprise Resource Planning (ERP) solution. An ERP system is a suite of fully integrated software applications that are used to perform administrative business processes such as financial management, procurement, personnel, and payroll administration. The Facilities Management Contractor must make all appropriate changes for the TennCare Management Information System (TCMIS) interface with Edison, the new State of Tennessee's Enterprise Resource Planning Solution. The first phase targeted is the Human Resources/Payroll. Other modules to be implemented include Procurement, Financial Management and Logistics. The expected start date for the Implementation Phase of the

Edison Project is FY06, with Human Resources/Payroll functionality going into production in FY08. To accommodate normal State business operations, the Edison system will be available for production usage prior to that date so that State business commences on that date. The State would like to deploy the Financials and Procurement/Logistics functionality in multiple waves, with a balanced schedule of deploying agencies over no more than nine (9) months. The first wave will deploy at the start of the new State fiscal year 2009 (July 1, 2008). All these modules will access one (1) centralized database.

When implemented, the TCMIS will need to be modified to interface with the new, fully integrated systems, or modules, of Edison, which utilizes PeopleSoft®. This interface transmits and receives critical financial information, including accounts payable data, accounts data, business contracts, budget, premium, drug rebates, and draw down of federal funds. This interface must support processing all financial payment transactions through the new ERP system including provider, MCCs, Medicare Buy-In, HIPP, and enrollee refunds and reimbursements.

The overall impact on the TCMIS applications is not known at this time. The interfaces between interChange and the PeopleSoft® financial application will undoubtedly require modifications at least to a moderate degree. Any items such as interface frequency changes and the associated maintenance costs to support the interfaces are unknown at this point. It is recommended that the Contractor establish an initial project management and scope assessment team to establish an implementation 'point of contact' and collaborative Subject Matter Expert (SME) during the initial project phases and perhaps influence the design or minimize the design impact on the TCMIS systems and applications as Project Edison progresses through the development lifecycle.

The system modifications for this initiative are not included in this Contract Proposal. A separate Work Order will be issued for this implementation as this project evolves.

Additional information can be found in the RFP and Proposal for the Edison (ERP) project.

6.10.1.3. CMS's MITA Initiative

The Medicaid Information Technology Architecture (MITA) initiative of the Centers for Medicaid and State Operations (CMSO) is a structured effort to provide a national architecture framework in which Medicaid business areas drive technology. MITA defines a set of principles and guidelines which are models for documenting Medicaid business and technology, data and technical standards, recommended solutions for business and technology requirements, and guidelines for adapting MITA State-specific goals and objectives. It is intended to foster integrated business and Information Technology (IT) transformation across the Medicaid enterprise to improve the administration of the Medicaid program. The MITA Initiative is a national framework to support improved systems development and health care management for the Medicaid enterprise.

MITA can improve Medicaid program administration by aligning business processes and supporting technology with national guidelines. The MITA initiative includes the framework, processes, and planning guidelines that allow states to meet their objectives within the MITA Framework 2.0 while continuing to support the unique State needs.

The MITA Framework 2.0 is a consolidation of principles, business and technical models, and guidelines that creates a template for States to use to develop their individual enterprise architectures. The MITA processes provide guidance to State Medicaid enterprises on how to adopt the MITA Framework 2.0 through shared leadership, partnering, and reuse of solutions. The MITA planning guidelines help States define strategic MITA goals and objectives and develop tailored enterprise architectures that are

consistent with CMS expectations. In the future, MITA guidelines will support States' requests for appropriate Federal Financial Participation (FFP) for their Medicaid Management Information Systems (MMISs).

CMS expects the Bureau of TennCare to take steps to migrate toward the new Medicaid Information Technology Architecture (MITA) framework. The Bureau is committed to the guidelines and objectives for MITA (included below from the MITA Framework 2.0 dated March 2006) and is preparing for future enhancements to meet those objectives:

- Adopt data and industry standards
- Promote reusable components; modularity
- Promote efficient and effective data sharing to meet stakeholder needs
- Provide a beneficiary-centric focus
- Support interoperability, integration, and an open architecture
- Promote secure data exchange (single entry point)
- Promote good practices (e.g. the Capability Maturity Model [CMM] and data warehouse)
- Support integration of clinical and administrative data
- Break down artificial boundaries between systems, geography, and funding (within the Title XIX Program)

6.10.1.4. NPI Assessment and Implementation

The Unique Health Identifier for Health Care Providers (named National Provider Identifier - NPI) rule was published on January 23, 2004, with the effective date of May 23, 2005. This rule establishes a standard for using a nationally assigned, "non-intelligent" provider identifier required to be used in electronic health care transactions. The National Provider Identifier (NPI) is a ten (10) digit numeric unique identifier, with an International Standard Organization (ISO) check-digit in the tenth (10th) position. NPI is mandated under HIPAA with a scheduled implementation date of May 23, 2007.

The NPI is required whenever the HIPAA Implementation Guides require a provider identifier in a standard transaction. Current federal legislation requires that the National Provider Identifier be utilized in all HIPAA "standard" EDI transactions beginning May 23, 2007, (e.g. X12 837 claims transactions must carry NPI in order for providers to be paid). Legacy identifiers cannot be used after May 23, 2007.

The Bureau implemented NPI by preparing an NPI Assessment and Remediation Plan for all TCMIS systems and interfaces. This assessment included: Gathering documentation of Policies, Procedures, and Systems; Analysis of Interfaces, Reports, and Windows; Assessment of Business Policies and Processes; Impact and Gap Analysis; and a Remediation Plan.

The Contractor must support and maintain NPI processes and procedures according to HIPAA and Bureau requirements.

6.10.1.5. Spend Down

According to the "TennCare Three (3) Year Information Systems Plan" dated July 3, 2006, TennCare "Plans to add forty thousand (40,000) new eligibles to the program and move 60,000 current eligibles to the new 'Standard Spend Down' program during the

coming year. (The "Standard Spend Down" program is a program that the Administration committed to implement in a 2005 Memorandum of Understanding with the Plaintiffs-Interveners in the Grier lawsuit)".

A Medicaid spend down is for individuals who meet all of the Medicaid eligibility requirements except for income. People who have countable income higher than the medically needy income limit for their city or county are placed in a spend down program. Medically Needy Spend Down is an optional Medicaid category offered by TennCare. It is designed to provide temporary healthcare coverage when a person has excessive unpaid medical bills that cause their income to diminish. As a result, their income would then meet the qualifying levels.

Modifications to the TCMIS will be necessary to implement this benefit program.

6.10.1.6. Governor's eHealth Initiatives

Tennessee's Governor is striving to implement several eHealth initiatives. Providing a Statewide eHealth network for information exchange will reduce costs and improve the quality of healthcare by improving coordination of care between hospitals, physicians, and other healthcare professionals.

6.10.1.6.1. Clinical Health Records through Shared Health

As part of the Governor's portfolio of eHealth initiatives, the Bureau of TennCare contracted with Shared Health to implement a Clinical Health Record (CHR) for the TennCare population. The goal of the CHR is to improve the quality of care by making current medical information available to providers, presenting a complete view of claim and prescription history to help to avoid duplicate testing, unnecessary procedures, and harmful drug interactions. The Bureau of TennCare began working with Shared Health in the fall of 2005 to develop eligibility, provider and claims data transfer formats, to test the application and verify display of accurate information, and to refine security and privacy practices. The Bureau of TennCare implemented the CHR in fall of 2006 following distribution of notice of privacy practices and procedures for opt-out to the entire program population.

Shared Health is transforming health care by offering innovative health information technology solutions that improve quality and lower cost. The Shared Health Clinical Health Record is a web-based application unique from other web-based Electronic Health Records (EHRs) in that it provides more comprehensive patient information, including patient demographic information, medical diagnoses and procedures, medications, allergies, vital signs and immunizations. Shared Health also allows authorized physicians to securely order prescriptions through its ePrescribeTM online function, ensuring the safety and cost-effectiveness of medications while eliminating the need for traditional paper prescriptions.

In addition to being the country's largest public/private electronic Health Information Exchange (HIE), the company also set a precedent by making Tennessee's Medicaid program, TennCare, the first Medicaid program in the country to convert all beneficiaries to an electronic health record application. The CHR program now includes members covered by all TennCare Managed Care Contractors (MCCs).

6.10.2. TCMIS Overview

Prior to the implementation of the TennCare Waiver in 1994, the State of Tennessee provided a full range of services to Medicaid eligible individuals. Contracted providers

submitted claims for services directly to the Bureau of Medicaid. Payments to providers were paid on a pre-determined fee schedule. The payments and remittance advices were mailed from the State's Facility Manager directly to providers.

Then, on January 1, 1994, Health Care Financing Administration (HCFA), now known as Centers for Medicare and Medicaid Services (CMS), approved an 1115 waiver. The State of Tennessee expanded benefit coverage beyond the Medicaid eligible population to include previously uninsured and uninsurable individuals. The TennCare Waiver changed from a fee-for-service reimbursement to a capitation process. Most health care services were delivered through Managed Care Contractors, and payments were managed through prepaid service contracts with various Managed Care Contractors (MCCs) located throughout the thirteen (13) regional areas defined by the State.

The MCCs provide a full range of medical services, mental health services, dental, and pharmacy benefits, which are delivered by the following types of Managed Care Contractors:

1) Managed Care Organizations (MCOs)

Enrollees receive all medical services through the MCOs except for long-term care services, Medicare primary benefits, Medicare cost sharing for persons with Medicare dual eligibility and other waiver programs (HCBS and DCS).

2) Behavioral Health Organizations (BHOs)

The Bureau of TennCare contracts with two (2) Behavioral Health Organizations to provide mental health and substance abuse services for TennCare enrollees. BHOs partner with MCOs to coordinate the overall healthcare for enrollees. In 2007, two (2) new MCOs began providing both behavioral and medical care to their enrollees in middle Tennessee.

3) Pharmacy Benefits Manager (PBM)

In July 2003, all pharmacy services were carved out to a single Pharmacy Benefits Manager (PBM). (Prior to this time, only some pharmacy services were covered by the PBM.)

4) Dental Benefits Manager (DBM)

In Oct. 2002, a dental carve-out program was initiated, and the State contracted with a Dental Benefits Manager (DBM) to provide dental benefits to TennCare eligible children.

5) Other Care Management

Services are provided to eligible recipients in Long Term Care (LTC) facilities (e.g. Skilled Nursing Facilities (SNF)), and Intermediate Care Facilities (ICF/MR) for the Mentally Retarded. Additional services for special needs populations, who would otherwise require institutional care, are covered under a CMS approved 1915c Home and Community Based Service (HCBS) waiver program that provides services for the mentally retarded or the elderly and disabled. Another care management program is the Program of All-inclusive Care for the Elderly (PACE). A recipient must undergo a Preadmission Evaluation (PAE) referral process to qualify for these care management programs.

Since the TennCare program was first implemented as a five (5) year demonstration program in 1994, it has received several extensions by the Centers for Medicare and Medicaid Services (CMS), formerly HCFA. In July 2002, a new five (5) year program began. In the spring of 2005, TennCare Reform began modification procedures to bring spending costs more in line with other states.

On August 1, 2005 in an effort to control healthcare costs, TennCare applied restrictions on benefits. The benefit changes that were implemented limited or even eliminated certain services for enrollees, depending on the Benefit Package that was associated with the enrollee's eligibility category. Because of TennCare Reform rules changes, thousands of TennCare enrollees were no longer eligible to receive benefits.

The Bureau of TennCare is organized into functional business units, which are responsible for project management, administrative services, information systems, managed care programs (including provider networks, pharmacy), Finance, Contract Compliance, Long Term Care, Member Services, Program Development, General Council, Medical Review services, and Communications.

The existing TCMIS is maintained and operated by a Facilities Manager. The interChange system, implemented by EDS, uses a centralized operational database that uses relational technology. The system was designed to meet the complex management and information needs required by the Bureau of TennCare. A description of each TCMIS functional component is provided within each functional section of the RFP.