AGREEMENT
BETWEEN
THE HEALTH AND HUMAN SERVICES COMMISSION
AND
ACCENTURE STATE HEALTHCARE SERVICES LLC
FOR
TEXAS MEDICAID MANAGEMENT INFORMATION SYSTEM
TAKEOVER

RFP No. 529-16-0007

AGREEMENT
BETWEEN
THE HEALTH AND HUMAN SERVICES COMMISSION
AND
ACCENTURE STATE HEALTHCARE SERVICES LLC
FOR
TEXAS MEDICAID MANAGEMENT INFORMATION SYSTEM TAKEOVER

EXHIBITS

A. **HHSC DATA USE AGREEMENT 7.4**
B. **STATEMENT OF WORK**
C. **FINANCIAL GOVERNING DOCUMENTS**
D. **CONTRACTOR FEE SCHEDULE**
E. **CORPORATE GUARANTEE**
F. **REQUIRED CERTIFICATIONS**

STATE OF TEXAS

COUNTY OF TRAVIS

AGREEMENT
BETWEEN
THE HEALTH AND HUMAN SERVICES COMMISSION
AND
ACCENTURE STATE HEALTHCARE SERVICES LLC
FOR
TEXAS MEDICAID MANAGEMENT INFORMATION SYSTEM TAKEOVER

Article 1. INTRODUCTION

THIS AGREEMENT (the "Agreement") is entered into between the HEALTH AND HUMAN SERVICES COMMISSION ("HHSC" or the "State"), an administrative agency within the executive department of the State of Texas and having its principal office at 4900 North Lamar Boulevard, Austin Texas 78751, and Accenture State Healthcare Services LLC ("CONTRACTOR"), a limited liability corporation organized under the laws of the State of Delaware and having its principal place of business at 1501 S. MoPac Expressway, Austin, TX 78746. HHSC and the CONTRACTOR may be referred to in this Agreement individually as a "Party" and collectively as the "Parties."

The Parties agree that the following terms and conditions apply to the Services and Deliverables to be provided by the CONTRACTOR under this Agreement in consideration of certain payments to be made by HHSC.

Article 2. BACKGROUND, INDUCEMENTS, AND OBJECTIVES

Section 2.01 *Background*

(a) *Federal legislative authorization*

This Agreement is entered into in connection with the Texas Legislature's decision to participate in the federally-authorized State Medicaid Program ("Medicaid"). Medicaid is a jointly-funded, Federal-State health insurance program for certain low-income and needy people. The program was enacted in 1965 under Title XIX of the Social Security Act.

(b) *State enabling legislation*

HHSC is the single state agency responsible for administering the Texas Medicaid program under Texas Government Code Section 531.021. As such, HHSC administers and maintains the Medicaid State Plan, the contract between the State and the Centers for Medicare & Medicaid Services that describes the nature and scope of Texas' Medicaid program.

(c) *Legal Authority*

(1) HHSC is authorized to enter into the Agreement under Chapter 531 and Section 2155.144, Texas Government Code. CONTRACTOR is authorized to enter into the Agreement pursuant to the authorization of its governing board or controlling owner or officer.

(2) The person or persons signing and executing the Agreement on behalf of the Parties, or representing themselves as signing and executing the Agreement on behalf of the Parties, warrant and guarantee that he, she, or they have been duly authorized to execute the Agreement and to validly and legally bind the Parties to all of its terms, performances, and provisions.

(d) *Inducements*

In making the award of the Agreement, HHSC relies on CONTRACTOR's assurances of the following:

(1) CONTRACTOR and its Subcontractors are established providers of the types of services described in solicitation 529-16-0007 issued September 16, 2015;

(2) CONTRACTOR and its Subcontractors have the skills, qualifications, expertise, financial resources, and experience necessary to perform the Services, and in this Agreement in an efficient, cost-effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities;

(3) CONTRACTOR has thoroughly reviewed, analyzed, and understood the solicitation, has timely raised all questions or objections to the solicitation of which it is aware as of the Effective Date of this Agreement, and has had the opportunity to review and fully understand HHSC's current program and operating environment for the activities that are the subject of the Agreement and the needs and requirements of the State during the Agreement term;

(4) CONTRACTOR has had the opportunity to review and understand the State's stated objectives in entering into the Agreement and, based on such review and understanding, CONTRACTOR currently has the capability to perform in accordance with the terms and conditions of the Agreement; and

(5) CONTRACTOR also has reviewed and understands the risks associated with the HHSC Programs as described in the solicitation, including the risk of non-appropriation of funds.

Section 2.02 ***Mission and Objectives***

(a) *Mission*

HHSC's mission for this Agreement is to continue to provide quality and necessary health care services to the segment of the Texas population with health benefits covered by the HHSC Programs.

(b) *Objectives*

The primary objective of this Agreement is to ensure that the critical services described in this Agreement are provided to HHSC's clients without interruption or delay, and with no degradation in quality in a manner consistent with legislative direction.

Article 3. General Contract Structure

Section 3.01 *Contract Elements*

The Agreement between the Parties consists of: this Final Executed Document; HHSC's Data Use Agreement 7.4 (Exhibit "A"); Statement of Work (including all attachments and exhibits thereto) (Exhibit "B"); Financial Governing Documents (Exhibit "C"); CONTRACTOR Fee Schedule (Exhibit "D"); CONTRACTOR's Corporate Guarantee (Exhibit "E"); and Required Certifications (Exhibit "F"). The foregoing documents reflect the Parties' negotiation on: the solicitation; CONTRACTOR's proposal; HHSC's Uniform Terms and Conditions; all required terms in those documents; and any other Party agreements.

Section 3.02 *Order of Documents*

Notwithstanding any provision in the Agreement to the contrary, in the event of any conflict or contradiction, these documents will control in the following order of precedence:

1. This Final Executed Agreement;
2. HHSC's Data Use Agreement 7.4 (Exhibit "A");
3. Statement of Work and its attachments (Exhibit "B");
4. Financial Governing Documents (Exhibit "C")
    a. Financial Cost Standards ("Attachment 1 to Exhibit C")
    b. Cost Principle Manual ("Attachment 2 to Exhibit C")
    c. CONTRACTOR'S Accounting Policy Manual ("Attachment 3 to Exhibit C")
5. CONTRACTOR Fee Schedule (Exhibit "D");
6. CONTRACTOR's Corporate Guarantee (Exhibit "E"); and
7. Required Certifications (Exhibit "F").

Section 3.03 *Definitions*

Capitalized terms in this Agreement shall have the following definitions:

1. "A-3 Operations Pricing Schedules" is defined as the Microsoft Excel file titled "A-3 Operations Pricing Schedules-FINAL-20170428" submitted for purposes of CONTRACTOR's final operational cost proposal dated April 28, 2017.

2. "Accounting System" is defined in Section I of Attachment 3 to Exhibit C.

3. "Actual Allowable Cost Report" is defined in Section II of Attachment 2 to Exhibit C.

4. "Additional Recurring Activity Charges" are the recurring Fees for pricing of change order requests, and their associated Amendments, set forth in Exhibit C

5. "Administrative Service Fee Rate" is defined as the rate applicable to CONTRACTOR's performance of the Services as detailed in Exhibit C.

6. "Agreement" is defined in Article 1.

7. "Allocable Costs" is defined in Section II of Attachment 2 to Exhibit C.

8. "Allowable Costs" is defined in Section II of Attachment 2 to Exhibit C.

9. "Applicable Law" is defined in Section 9.03.

10. "ARC/RRC" is defined in Section 4.09.

11. "Business Day(s)" shall mean the days following the receipt of the item being measured, but not the actual day of receipt, excluding weekends and State approved holidays.

12. "Business Hours" is defined as 8:00 a.m. through 5:00 p.m. Central Time.

13. "CIP" is defined in Section 7.01.

14. "Common Support Overhead Rate" is defined as the rate applicable to CONTRACTOR's overhead associated with CONTRACTOR's Employee labor costs as detailed in Exhibit C.

15. "Confidential Information" is defined in Section 2.01 of the Data Use Agreement attached hereto as Exhibit A.

16. "Contingency Fees" are defined in Section 2(e) of Exhibit C.

17. "CONTRACTOR" is defined in Article 1.

18. "CONTRACTOR Rates" are defined as the rates set forth in Exhibit D-04, and include Predetermined Rates.

19. "CONTRACTOR Unit Rates" are the per unit amounts to be paid to CONTRACTOR for Services performed by applicable Subcontractors as set forth in Exhibit D1.03(b)(2).

20. "Corrective Action Plan" or "CAP" is defined in Section 10.03(b).

21. "Cost Shortfall" are defined in Section 7 of Exhibit C.

22. "Cost Surplus" are defined in Section 7 of Exhibit C.

23. "Custom Software" is defined in Section 14.02.

24. "Cyberterrorism" means computer-based attacks perpetuated by a third party aimed at disabling or disrupting vital computer systems to cause harm, disrupt business or government operations or further social, ideological, religious, political or similar objectives to intimidate, coerce, or harm a government or section of the population.

25. "Deliverable" means tangible work product prepared by CONTRACTOR for HHSC as specified in the Statement of Work.

26. "DED" is defined in Section 4.06(b).

27. "Direct Cost" is defined in Section II of Attachment 2 to Exhibit C.

28. "Directly Associated Cost" is defined in Section II of Attachment 2 to Exhibit C.

29. "Effective Date" is defined in Section 3.04(b).

30. "Employees" are the employees of CONTRACTOR and Subsidiaries, but shall explicitly not include any employees of Accenture Federal Services, LLC.

31. "Fee Schedules" is defined in Section 6.01(a).

32. "Fees" is defined in Section 6.01(a).

33. "Fixed Fees" are the Fees paid for Services performed on a "fixed fee" basis, as set forth in Exhibit D-01.

34. "Fringe Benefit" is defined in Section II of Attachment 2 to Exhibit C.

35. "Fringe Benefit Rate" is defined as the rate applicable to CONTRACTOR's Employee salaries as detailed in Exhibit C.

36. "Functional Requirements" is defined in Section 4.01.

37. "HHSC" is defined in Article 1.

38. "HHSC Programs" are defined as follows:

- Core Title XIX (includes all Services not otherwise covered by programs below)
- Children with Special Health Care Needs (CSHCN) Services Program
- Family Planning Title V and XX (FP)
- Long Term Care (LTC)
- Medical Transportation Program (MTP)
- Healthy Texas Women's program (formerly Texas Women's Health Program)

39. "HIPAA" is defined in Section 8.13.

40. "Indirect Costs" is defined in Section II of Attachment 2 to Exhibit C.

41. "Indirect Rate" is defined as the rate applicable to specified CONTRACTOR costs as detailed in Exhibit C.

42. "Initial Term" is defined in Section 3.04(b).

43. "Key Assumptions" is defined in Section 3.05.

44. "Key Measures" is defined in Section 4.01.

45. "Key Personnel" are identified pursuant to the Functional Requirements Exhibit B.

46. "Liability Cap" is defined in Section 13.05(a).

47. "Medicaid contractor" is defined in Section 8.11.

48. "Medicaid" is defined in Section 2.01(a).

49. "Modernization Activities" is defined in Section 4.07.

50. "Operational Contract Year" is defined in Section 3.04(c)

51. "Operational Start Date" shall be August 1, 2017.

52. "Operations" shall mean the Services that are not Transition or turnover services.

53. "Party" is defined in Article 1.

54. "Pass-Through Expenses" is defined in Section 2(d) of Exhibit C.

55. "Payment Schedule" is defined as the Payment Schedule used by CONTRACTOR to invoice for its Fees for Services and Deliverables under this Agreement attached at Exhibit D hereto.

56. "Predecessor Contract Amendment Fees" is defined as Fixed Fees for amendments from the predecessor contract #529-14-0125-0003.

57. "Predetermined Rates" are defined collectively as: (1) the Administrative Service Fee Rate, (2) the Common Support Overhead Rate, (3) the Indirect Rate; and (4) the Fringe Benefit Rate.

58. "Primary Subcontractor" is a Subcontractor that performs greater that fifteen percent (15%) of the Services. As of the Effective Date there are no Primary Subcontractors under this Agreement.

59. "Priority Interfaces" are defined as technical systems prioritized by criticality and set forth in Exhibit "B".

60. "Productivity Benefit" is defined in Section 7(b)(2) of Exhibit C.

61. "Productivity Discount" is defined in Section 7(b)(2) of Exhibit C.

62. "Productivity Share" is defined in Section 7.02.

63. "Provider Relations" is defined in Section II of Attachment 2 to Exhibit C.

64. "Reasonable" is defined in Section II of Attachment 2 to Exhibit C solely for the purposes described therein.

65. "Review Period" is defined in Section 4.06(a).

66. "RCS Ceiling" is defined in Exhibit C.

67. "Retrospective Cost Settlement" or "RCS" is defined in Section 7 of Exhibit C.

68. "Service Month" is defined in Section 10.03(f).

69. "Services" is defined in Section 6.01.

70. "Steering Committee" is defined in Section 3.06

71. "Subcontractor" is a third party with whom CONTRACTOR enters into an agreement to provide services under this Agreement. For avoidance of doubt, CONTRACTOR's parent entities, subsidiaries or affiliates are not Subcontractors.

72. "Subsidiaries" is defined in Section II of Attachment 2 to Exhibit C.

73. "Sustained Change" is defined as the three months immediately preceding the month of service consistently above or consistently below the dead band as described Exhibit D to this Agreement.

74. "Systems Maintenance and Modification Fees" are the implementation Fees for pricing of change order requests, and their associated Amendments, set forth in Exhibit C.

75. "Term" means the duration of the Agreement, as further described in Section 3.04.

76. "Third Party Resources" is defined in Section 2(d) to Exhibit C.

77. "THSteps" is defined in Section 2.02(a).

78. "TMMIS" is defined as The Texas Medicaid Management Information System which is an integrated group of systems designed to support all activities associated with the Texas Medicaid Program. The system includes technology that enables functions such as

eligibility verification, claims payment, provider enrollment, prior authorization, response to provider and client inquires (e.g. call center) as well as data and reports for Medicaid Program administration and audit. The system supports the objective of providing cost-effective care and improved health outcomes. The specific components of the TMMIS are set forth in Exhibit B.

79. "Transition" shall mean the Functional Requirements in Attachment 35 to Exhibit B and the Key Measures designated as "TRN" in Attachment 37 to Exhibit "B".

80. "Transition Fees" are the Fees paid for CONTRACTOR's performance of the Services described by Exhibit D-01.

81. "Variable Baseline Fees" are defined in Section 2(b) of Exhibit C and set forth in Exhibit D-03(a).

82. "Variable Unit Rate Fees" are defined in Section 2(c) of Exhibit C and set forth in Exhibit D-03.

83. "VDP" is defined in Section 2.02(a).

Section 3.04 ***Term of the Agreement***

(a) *General Provisions*

This Section 3.04 will govern the period for performance of this Agreement. No commitment of funds is permitted prior to the first day or subsequent to the last day of the Initial Term and any properly executed extension of the Initial Term. The Term of the Agreement may be extended or shortened by amendment.

(b) *Initial Term*

Subject to early termination as permitted herein, the Term of the Agreement begins on the date of execution by both Parties (the "Effective Date") and ends 37 months after August 1, 2017 (the "Initial Term").

(c) *Operational Contract Years*

For purposes of establishing the appropriate operational contract years, the Parties agree to the following time periods:

Operational Contract Year 1: August 1, 2017– August 31, 2018

Operational Contract Year 2: September 1, 2018 – August 31, 2019

Operational Contract Year 3: September 1, 2019 - August 31, 2020

HHSC and CONTRACTOR agree that transition activities will commence upon the Effective Date and will conclude no later than July 31, 2017 unless otherwise agreed by the Parties. In the event the transition activities do not timely commence as set forth in this paragraph, the Parties agree to make necessary adjustments to the Statement of Work, CONTRACTOR's Transition Fees and activities, or other aspects of this Agreement.

(d) *Optional Extensions of Agreement*

The Initial Term may be extended by the Parties for up to three one-year periods or to the extent necessary to complete the mission and objectives of this Agreement. Any extension of the Agreement will be commemorated in an amendment to this Agreement, subject to the requirements of Article 9 of this Agreement.

Section 3.05 ***Failure of Key Assumptions***

The Parties acknowledge that CONTRACTOR's ability to perform the Services described herein may be compromised by any failure of the fundamental assumptions (each, a "Key Assumption") set forth in Exhibit "B". In such instances, CONTRACTOR's effort, Fees and the project work plan will be adjusted if necessary to account for such failures.

Section 3.06 ***Project Leadership***

The Parties will convene a steering committee monthly, or as otherwise agreed to by the Parties, consisting of designated executives of the Parties, including, without limitation, the State Medicaid Director; the HHSC Deputy Executive Commissioner for Information Services; CONTRACTOR's Senior Managing Director, Operations; the CONTRACTOR Project Sponsor; the CONTRACTOR Project Director; the CONTRACTOR Finance Manager; the CONTRACTOR Commercial Director; and CONTRACTOR's Technology Lead (or the designee(s) of such individuals) ("Steering Committee"). The Steering Committee shall not have power to modify the Agreement except by mutual consent of the Parties as further set forth in Article 9.

The following individuals will serve as Project Sponsors:

CONTRACTOR

Jonathan P. Andrews
President
Accenture State Healthcare Services LLC
1501 S. MoPac Expwy. Suite 300
Austin, TX 78746

HHSC

William "Tony" Owens
Health and Human Services Commission
4900 N. Lamar Blvd.
Austin, TX 78751

The following individuals will serve as Project Directors and will serve as the primary contacts for all administrative issues:

CONTRACTOR

Terry Westropp
Accenture State Healthcare Services LLC
1501 S. MoPac Expwy. Suite 300
Austin, TX 78746

HHSC

Mirsa Douglass
Health and Human Services Commission
4900 N. Lamar Blvd.
Austin, TX 78751

Section 3.07 *Notice*

(a) *Oral Notice*

All communications concerning this Agreement should be in written form. However, a Party may provide oral notice when circumstances are such that immediate notification should be provided, and will be deemed to have been given when the oral communication has been delivered in person, by telephone, or otherwise to the Project Directors identified in Section 3.06 above and provided that additional written notice is submitted within 3 business days thereafter. Those who are authorized to provide oral notice for the Parties are:

For HHSC:

Project Sponsors

For CONTRACTOR:

Project Sponsors

(b) *Written Notice*

Written Notice will be deemed to have been given:

1. Upon the expiration of three (3) business days after the date of mailing if sent by registered or certified U.S. mail, postage prepaid, with return receipt requested;
2. When transmitted if sent by facsimile, provided a confirmation of transmission is produced by the sending machine;
3. When delivered if delivered personally or sent by express courier service; or
4. Through the vendor initiated correspondence or state action request processes for routine communications, or those that are administrative in nature.

Routine communications, or those that are administrative in nature, should be sent to the Project Directors identified in Section 3.06. All other contract notices will be sent to the other Party at its address set forth in this Agreement or such other address as is provided by a Party in accordance with the provisions of this Section:

If to HHSC:

Charles Smith
Executive Commissioner
Health and Human Services Commission
P.O. Box 13247
Austin, Texas 78711-3247

With Required Copy to:

Karen Ray
Chief Counsel
Health and Human Services Commission
P.O. Box 13247
Austin, Texas 78711-3247
Fax: 512-424-6586

If to CONTRACTOR:

Jonathan P. Andrews
President
Accenture State Healthcare Services LLC
1501 S. MoPac Expwy. Suite 300
Austin, TX 78746

With Required Copy to:

C. Ben Foster
Secretary
Accenture State Healthcare Services LLC
1501 S. MoPac Expwy. Suite 300
Austin, TX 78746
Fax: 704-348-4833

Either Party may change the above-referenced designees or address with five days written notice to the other Party.

Section 3.08 ***Construction of Agreement***

(a) *Scope of Introductory Article.*

The provisions of any introductory article to the Agreement are intended to be a general introduction and are not intended to expand the scope of the Parties' obligations under the Agreement or to alter the plain meaning of the terms and conditions of the Agreement.

(b) *References to the "State."*

References in the Agreement to the "State" mean the State of Texas unless otherwise indicated and will be interpreted, as appropriate, to mean HHSC and other agencies of the State of Texas that may participate in the administration of HHSC Programs, provided, however, that no provision will be interpreted to include any entity other than HHSC as the contracting agency.

(c) *Severability.*

If any provision of the Agreement is for any reason held to be unenforceable, the rest of it remains fully enforceable.

(d) *Survival of terms.*

Termination or expiration of the Agreement for any reason will not release either Party from any liabilities or obligations set forth in the Agreement that:

(1) The Parties agree will survive the termination or expiration; or

(2) Remain to be performed and by their nature would be intended to be applicable following any such termination or expiration.

(e) *Headings.*

The article and section headings in the Agreement are for reference and convenience only and may not be considered in the interpretation of the Agreement.

(f) *Global drafting conventions.*

(1) The terms "include," "includes," and "including" are terms of inclusion and enlargement, and where used in the Agreement, should be read as if followed by the phrase "without limitation."

(2) Any references to "sections," "appendices," or "attachments" are references to sections, appendices, or attachments of the Agreement.

(3) Any references to agreements, contracts, statutes, or administrative rules or regulations in the Agreement are references to these documents as amended, modified, or supplemented from time to time during the term of the Agreement.

Article 4. Scope Of Work

Section 4.01 *Statement of Work and Requirements*

The Statement of Work is attached hereto as Exhibit B. It includes the Services, requirements and performance standards to be performed by CONTRACTOR (if liquidated damages apply, "Key Measures"; if no liquidated damages apply, "Functional Requirements"), as well as the Deliverables, Key Assumptions, obligations and responsibilities of each Party related thereto, and the general governance provisions for the relationship of the Parties. When the Functional Requirements or Key Measures indicate that CONTRACTOR will perform an obligation or duty "as directed by the State," "as requested by the State" or "within a timeframe specified by the State" or similar statements, the State shall act reasonably in such determination, but a requirement containing a specific timeframe shall be deemed reasonable for purposes of this Section.

Section 4.02 *CONTRACTOR Responsibilities*

(a) CONTRACTOR will perform the Services required under this Agreement and other responsibilities as explicitly set forth in this Agreement and the Statement of Work. For clarity, the following services are out of scope and not included in the Services:

(i) Actuarial services, actuarial advice, or any service requiring the opinion of a qualified actuary.

(ii) Direct patient care or the rendering of medical advice relating to patient care, telenursing and/or telemedicine.

(b) CONTRACTOR will not take any action substantially or materially inconsistent with any of the terms and conditions set forth in the Agreement without the written approval of HHSC.

(c) CONTRACTOR may be required to provide factual testimony in legal proceedings relating to HHSC Programs, but any request to provide expert testimony shall be subject to mutual agreement. CONTRACTOR shall not provide legal advice to the State. Without limiting CONTRACTOR's obligation to act as the agent of the State in fair hearings or subrogation proceedings, CONTRACTOR shall not represent the State in disputes, administrative proceedings or litigation, although it will assist the State in preparing its case for such disputes. CONTRACTOR will work under the direction of the State and its legal counsel regarding the specific legal and regulatory requirements under which the Medicaid program operates.

(d) CONTRACTOR will remain in compliance with the certifications presented with its proposal, including the certifications set forth in Exhibit F, and will update HHSC if there is any material change to said certifications.

Section 4.03 ***HHSC Responsibilities***

HHSC will monitor and supervise, as required by Applicable Laws, all CONTRACTOR responsibilities, assess performance and determine satisfaction with the requirements of this Agreement. HHSC will perform such other responsibilities as explicitly set forth in this Agreement and the Statement of Work.

Section 4.04 ***HHSC Delays***

The Parties acknowledge that the work effort is divided between the Parties, as set forth in the Statement of Work. In the event of a demonstrated delay or failure by HHSC (or the delay or failure of HHSC's employees, agents or contractors, not including CONTRACTOR) that causes an increase in the time, effort or resources necessary for CONTRACTOR to perform the Services, then: (a) CONTRACTOR will not be in default or liable for the portion of any damages or loss resulting from such failure or delay; and (b) HHSC and CONTRACTOR will modify the Agreement as appropriate to adjust the Fees (and if appropriate, the RCS Ceiling), scope of work and/or schedule.

Section 4.05 ***Deliverable Acceptance***

(a) *Review Period*

HHSC will accept or reject Deliverables within twenty (20) business days of delivery ("Review Period"), with written detail of deficiencies if such Deliverable is rejected. If HHSC does not either accept or reject the applicable Deliverable, or the Parties have engaged in discussions regarding the acceptability of the Deliverable or the applicable requirements, within the Review Period, then CONTRACTOR will provide written notice

to HHSC that such determination is overdue. HHSC shall then have an additional two (2) business days to accept or reject such Deliverable from receipt of the notice of expiration of the Review Period. If HHSC has not accepted or rejected the Deliverable after the additional two (2) business day review period, then the applicable Deliverable shall be deemed accepted. The Review Period may be increased or decreased for individual Deliverables by mutual agreement of the Parties in writing.

(b) *Deliverable Expectation Document*

For each Deliverable where the Statement of Work designates that a deliverable expectation document (a "DED") is required, CONTRACTOR will develop and propose for HHSC's approval an applicable DED that sets forth the scope, contents, due date and acceptance criteria for such Deliverable. Deliverable acceptance will be contingent on material compliance with the approved DED.

(c) *Reliance*

CONTRACTOR reasonably shall be entitled to rely on HHSC's acceptance of the Services and Deliverables and approvals provided under this Agreement. If a Deliverable due date falls on a weekend or holiday, such Deliverable will be submitted on the latest business day prior to the weekend or holiday.

Section 4.06 ***Performance Measurement***

Satisfactory performance of the Agreement will be measured by:

(a) Adherence to the Agreement, including all representations and warranties;

(b) Compliance with project work plans, schedules, and milestones as proposed by CONTRACTOR and finally approved by HHSC;

(c) Delivery of the Services and Deliverables in accordance with the service levels set forth in the Statement of Work;

(d) Results of audits performed by HHSC or its representatives in accordance with this Agreement;

(e) Timeliness, completeness, and accuracy of required Deliverables; and

(f) Achievement of performance measures developed by the Parties and as modified from time to time by written agreement during the Term of the Agreement.

Section 4.07 ***Modernization Initiatives***

CONTRACTOR understands that HHSC may commence modernization activities that result in HHSC decoupling business functions, Key Measures and/or the Functional Requirements within the Statement of Work and replacing it with updated business, technology, or functional components any time from the start of Operations phase to the end of the Term. CONTRACTOR will cooperate with HHSC on these modernization initiatives which may include HHSC's issuance of additional solicitations or offers to other potential contractors for performance of portions of the Services covered by the Agreement. The modernization initiatives may include services similar or comparable to the Services performed by CONTRACTOR under the Agreement.

Future termination of Services, programs or functional areas by HHSC may not result in a reduction in the Fees equal to the current allocation for a specific line item. The impact of the termination of Services, programs or functional areas to the Statement of Work and the Fees will be jointly assessed by the Parties after receipt of a notice of intent to terminate a component by HHSC.

Section 4.08 ***Key Measure Process and Calculation Method***

Prior to the Operational Start Date the Parties will establish the Key Measure Process and Calculation Method for the measurement and calculation of Key Measures for the Term of the Agreement by Minor Administrative Change.

Section 4.09 ***Statement of Work Revisions***

The Amendments to predecessor contract #529-14-0125-0003 between the Parties which are not incorporated into Fees will be set forth in Exhibit "B" at such time as the Parties reach agreement on the inclusion of such Amendments, and will be included in the Statement of Work as if fully represented therein. The Fees, if any, for resources properly utilized after the Effective Date will be billed separately as set forth in those Amendment's Fee Schedules unless otherwise addressed pursuant to Article 9.

The Parties agree to review factors materially impacting the Fees, Services and Deliverables independent of the Additional Resource Charge/Reduced Resource Credit ("ARC/RRC") structure, including the Key Assumptions in Exhibit "B" and the Key Measures and Process and Calculation Methods in Section 4.08 annually after the Effective Date. Following these reviews, the Parties may adjust the Services, Key Assumptions, Key Measures or other factors as necessary, including any applicable changes to the Fees.

Section 4.10 ***Application and Infrastructure Outsourcing***

As further described in the Functional Requirements, CONTRACTOR will perform technology services related to application and infrastructure outsourcing. These services include, but are not limited to, application maintenance and support; application enhancements, upgrades, and routine development; testing; data center, workplace, network, and security managed services; and service integration and management capabilities in an infrastructure environment.

Article 5. Governing Law and Regulations

Section 5.01 ***Governing Law and Venue***

This Agreement is governed by the laws of the State of Texas and interpreted in accordance with Texas law. Provided CONTRACTOR first complies with the procedures set forth in Section 8.15 below, proper venue for claims arising from this Agreement will be in a court of competent jurisdiction in Travis County, Texas.

Section 5.02 ***Governing Laws and Regulations***

(a) *Law and regulations governing administration of the Agreement*

CONTRACTOR will comply with the following laws and regulations:

(1) The Health and Insurance Portability and Accountability Act ("HIPAA") of 1996, Public Law 104-191, as amended and modified, to the extent set forth in Exhibit "A";

(2) Chapter 531, Chapter 2155.144, Chapter 2157 and Chapter 2254, Texas Government Code, as amended and any administrative rules adopted thereunder;

(3) 1 T.A.C. Chapter 391;

(4) All laws, regulations, and administrative rules that govern the performance of the Services including all state and federal tax laws, state and federal employment laws, state and federal regulatory requirements, and licensing provisions;

(5) Federal Immigration Laws, Anti-Discrimination Laws;

(6) Fraud, Waste, and Abuse requirements in HHS Circular C-027; and

(7) Any other pertinent provisions of federal law or regulation, and state law, rule or regulation.

For avoidance of doubt, the purpose of this Section is to confirm that CONTRACTOR complies with laws applicable to CONTRACTOR and its performance of the Services. Nothing in this Agreement shall be deemed to impose any obligation on CONTRACTOR to guarantee that HHSC is compliant with any laws applicable to HHSC or that the requirements herein are compliant with Applicable Laws. Where the Functional Requirements or Key Measures indicate that CONTRACTOR will ensure compliance with Applicable Laws, this shall mean that CONTRACTOR will comply with all directions, policies and rules established by HHSC for the programs subject to the Statement of Work. If CONTRACTOR interprets any Applicable Law where HHSC has not established directions or policies, and takes steps to implement such interpretation in the performance of any activities in the Statement of Work, including any Key Measures or Functional Requirement without the consent of HHSC, then it shall not be relieved of liability under this Section. Where, however, HHSC directs CONTRACTOR to take action, or refrain from taking action, and CONTRACTOR has a good faith belief that such direction would result in a failure to comply with Applicable Laws, then CONTRACTOR will not be held liable for any noncompliance with such Applicable Laws if CONTRACTOR provides the HHSC Project Director with reasonable notice of its good faith belief and HHSC directs CONTRACTOR to continue to perform as instructed.

Article 6. Financial Approach and Payment

Section 6.01 *Fees*

(a) *Financial Approach*

HHSC has chosen to use a "fixed price subject to retrospective cost settlement" approach related to the administrative services and a "fiscal agent" approach related to the medical benefit costs included in this Agreement. The financial aspects of the Agreement will be monitored in accordance with Applicable Laws, Exhibit C hereto, and HHSC guidelines, rules, regulations, and provisions applicable to programs within the scope of the Agreement.

The Services will be paid primarily on a "fixed price" basis, with CONTRACTOR's costs subject to further review and determination of reimbursement by HHSC as described in Exhibit C. CONTRACTOR will be entitled to the fees earned for correct performance of the Services and/or completion of the Deliverables ("Fees"), and reimbursement for the expenses incurred on behalf of HHSC or expenses incurred for the performance of the Services ("Pass-Through Expenses"), in the amounts or at the rates, as applicable, set forth in the schedules included in Exhibit D ("Fee Schedules"). "Services" under the Agreement means the tasks, functions, and responsibilities assigned and delegated to the CONTRACTOR, specifically the Statement of Work, and any ancillary or incidental tasks, functions or responsibilities not otherwise expressly described in the Agreement but which are customary or required for the performance or delivery of the Services in accordance with the Agreement. CONTRACTOR will be responsible for processing and providing payment instructions for paying medical benefit claims for HHSC Programs as further described in the Exhibit B. CONTRACTOR will act as a payment and verification agent in connection with the HHSC Electronic Visit Verification (EVV) vendor services agreements. CONTRACTOR will issue payments to EVV vendors on behalf of HHSC for fee for service eligible providers and clients, as authorized by HHSC, and validate EVV vendor invoices for accuracy. Except as provided in the Agreement, all other expenses incurred by the CONTRACTOR in connection with its provision of the Services or Deliverables will not be reimbursed by HHSC unless previously agreed to by HHSC.

(b) *Fee Types*

In consideration of CONTRACTOR's successful performance of the Services and supplying of the Deliverables, HHSC will pay CONTRACTOR the following Fees in accordance with Exhibit C:

1. Fixed Fees for the transition pricing components;
2. Fixed Fees for the Operations pricing components;
3. Variable Fees for the Operations pricing components;
4. Pass-Through Expenses for the pass-through components;
5. Contingency Fees;
6. Predecessor Contract Amendment Fees;
7. Systems Maintenance and Modification Fees to be paid for additional Services performed to modify the TMMIS; and
8. Additional Recurring Activity Charges.

(c) *Agreement Amount*

As of the Effective Date, the total estimated base contract value of the Agreement for the Initial Term is $645,879,413.68, but is subject to adjustment based on:

1. Changes in volumes related to the Variable Fees;
2. Actual costs incurred for Pass-Through Expenses;
3. Actual recoveries related to Contingency Fees;
4. Additional Recurring Activity Charges in accordance with Exhibit "C";

5. Systems Maintenance and Modification Fees in accordance with Exhibit "C"; and
6. Any extensions to the Term in accordance with Section 3.04(d).

HHSC anticipates that funds exceeding such total estimated base contract value will be expended under the Agreement due to the implementation of State and Federal mandates and other State initiatives that may require additions or changes to the Services.

Section 6.02 ***Payment of Fees***

Payment of each invoice submitted by CONTRACTOR under this Agreement will be made in accordance with Chapter 2251 of the Texas Government Code. HHSC, at its sole discretion, may choose to process only a portion of an invoice, if only a portion of an invoice can be verified and validated by the information submitted. If HHSC decides to process an invoice in this manner, an adjustment will be made by HHSC and only that portion of an invoice that can be verified and validated will be paid. To be paid for the invoice previously denied or not processed by HHSC, the CONTRACTOR must submit supplemental invoice(s) along with any and all corrections necessary.

Section 6.03 ***Retrospective Cost Settlement***

The Parties agree that the total maximum approved allowable cost of the Services and Deliverables supplied by CONTRACTOR to HHSC during each Operational Contract Year, according to the financial requirements of this Agreement, will be determined with the Retrospective Cost Settlement described in Exhibit C. The Parties intend that the RCS will be conducted in accordance with the negotiated standards of RCS application and construction in the Agreement. Where a term applicable to RCS is expressly defined, it is the Parties intent that the definition set forth in the Agreement controls and said term is not subject to any other interpretation or application.

Section 6.04 ***Required Federal Approval***

The Parties acknowledge that a portion of the Services and Deliverables will be funded, in part, by funds granted by the United States Department of Health and Human Services. Such federal funds comprise a substantial portion of the funds available to HHSC to pay for the Services and Deliverables and are provided pursuant to federal and state laws that authorize the State's participation in joint State-Federal public assistance and other human services programs. The Parties further acknowledge that, as a condition of such federal financial participation, HHSC must obtain the approval of the United States Department of Health and Human Services for all or a portion of this Agreement. Accordingly, the Parties agree that the mutual obligations of the Parties and each Party's duty to perform under this Agreement are strictly conditioned upon HHSC's receipt of such.

Section 6.05 ***Cost Accounting***

In no event shall CONTRACTOR be required to comply with any Cost Accounting Standards (popularly known as CAS) promulgated by the United States Government. The cost accounting methodology required by this Agreement is exclusively set forth in Exhibit "C".

Section 6.06 ***Inflation Adjustments***

The Parties acknowledge that the Fees, including the CONTRACTOR Rates include annual inflationary adjustments at the beginning of each Operational Contract Year. The Fees set forth in the Fee Schedule include this annual inflation adjustment.

If this Agreement is extended beyond the Term, both Parties acknowledge and agree that all Fixed and Variable Fees effective August 1, 2020, including the CONTRACTOR Rates, will be increased annually effective September 1 for each extension year by two percent (2%).

Article 7. Incentive Initiatives

Section 7.01 ***Continued Innovation Program***

HHSC is responsible for maximizing savings of tax payor funds and administering the functional areas of this Agreement in the most efficient manner possible. To that end, CONTRACTOR agrees that it will continue to identify innovations and improvements where the functional areas could be administered more efficiently and at a savings to the tax payors and the Parties have agreed to certain activities and corresponding incentive structures as part of a continued innovation program ("CIP"), which is more fully set forth in the Statement of Work. The Parties will agree in any given CIP project the method, if any, which that CIP project will be factored into the Section 7.02 Productivity Sharing provisions of the Agreement. CONTRACTOR will continue to report on the PA on Portal CIP initiated under the predecessor contract #529-14-0125-00003 between HHSC and CONTRACTOR.

Section 7.02 ***Productivity Sharing***

CONTRACTOR has included a two percent year over year productivity reduction each Operational Contract Year. This productivity reduction is reflected in the pricing schedules in Exhibit "D". The Parties have agreed to pursue further efficiencies in the Agreement through cost reductions where possible. The Parties agree to share the cost reductions resulting from operational efficiencies and productivity enhancements on a multi-tiered bases ("Productivity Share") as more fully set forth in Exhibit "C". The specific calculations for the Productivity Share will be done at the end of each Operational Contract Year and be done in conjunction with the Retrospective Cost Settlement.

Section 7.03 ***Self Reporting***

If there is a failure by CONTRACTOR to comply with a Key Measure and HHSC is unaware of such failure, then CONTRACTOR will be entitled to forgiveness from any applicable liquidated damages that may otherwise be assessable in a given month if CONTRACTOR provides prompt notice to the HHSC Project Director identified in Section 3.06, via the vendor initiated correspondence mechanism, of such noncompliance and a corrective action plan that remediates the underlying cause before the end of the following month.

Article 8. General Terms and Conditions

Section 8.01 ***Funding.***

The Agreement is conditioned on the availability of state and federal appropriated funds. Except for work that has already been performed in compliance with the Agreement, CONTRACTOR will have no right of action against HHSC in the event that HHSC is unable to perform its obligations under the Agreement as a result of the suspension, termination, withdrawal of funding to HHSC, the failure to fund HHSC, or lack of sufficient funding of HHSC for any activities or functions contained within the scope of the Agreement. If funds become unavailable, the provisions of Section 8.15 will apply. HHSC will use all reasonable efforts to ensure that such funds are available, and will negotiate in good faith with CONTRACTOR to resolve any CONTRACTOR claims for payment. HHSC will make best efforts to provide reasonable written advance notice to CONTRACTOR upon learning that funding for the Agreement may be discontinued.

Section 8.02 ***No Implied or Delegated Authority***

The authority delegated to CONTRACTOR by HHSC is limited to the terms of the Agreement. HHSC is the state agency designated by the Texas Legislature to administer the HHSC Programs, and no other state agency grants CONTRACTOR any authority related to the Agreement unless directed through HHSC. While CONTRACTOR will provide recommendations based on its experience and familiarity with similar programs, HHSC is the sole Party authorized to interpret Applicable Laws for the governmental programs described herein and shall retain responsibility for confirming that the Functional Requirements and Key Measures herein comply with Applicable Laws. CONTRACTOR is not delegated authority under the Agreement to:

(1) make public policy;

(2) promulgate, amend, or disregard administrative regulations or program policy decisions made by state and federal agencies responsible for administration of HHSC Programs; or

(3) unilaterally communicate or negotiate with any federal or state agency or the Texas Legislature on behalf of HHSC regarding the HHSC Programs or the Agreement.

CONTRACTOR is required to cooperate to the fullest extent possible to assist HHSC in communications and negotiations with state and federal governments and agencies as directed by HHSC. Whenever, by any provision of the Agreement, any right, power, or duty is imposed or conferred on HHSC, the right, power, or duty so imposed or conferred is possessed and exercised by HHSC's Executive Commissioner unless any right, power, or duty is delegated to the duly appointed agents or employees of HHSC. HHSC's Executive Commissioner will reduce any delegation of authority to writing and provide a copy to CONTRACTOR on request.

Section 8.03 ***No Waiver of Sovereign Immunity***

The Parties agree that no provision of the Agreement is in any way intended to constitute a waiver by HHSC or the State of Texas, or by CONTRACTOR (with respect to third parties

as an agent of the State) of any immunities from suit or from liability that HHSC, the State of Texas or CONTRACTOR may have by operation of law.

Section 8.04 ***Force Majeure***

A Party will not be liable for any failure or delay in performing its obligations under the Agreement if such failure or delay is due to any cause beyond the reasonable control of such Party, including, but not limited to, unusually severe weather, strikes, natural disasters, fire, civil disturbance, acts of Cyberterrorism or similar attacks, epidemic, war, court order, or acts of God. The existence of such causes of delay or failure will extend the period of performance in the exercise of reasonable diligence until after the causes of delay or failure have been removed. Each Party must inform the other in writing with proof of receipt within five (5) business days of the existence of a force majeure event.

Section 8.05 ***Cooperation with HHSC and state administrative agencies***

(a) *Cooperation with HHSC contractors and representatives*

CONTRACTOR agrees to reasonably cooperate with and work with the State's contractors, subcontractors and third-party representatives as requested by HHSC. HHSC agrees to reasonably cooperate with CONTRACTOR and to use its best efforts to ensure that HHSC's other contractors reasonably cooperate with CONTRACTOR. Neither party shall be required under this Section 8.05 to provide Confidential Information to a third party unless such party has executed a reasonable non-disclosure agreement applicable to such Confidential Information or otherwise allowed access to such Confidential Information as set forth in this Agreement.

(b) *Cooperation with state and federal administrative agencies*

CONTRACTOR must ensure that CONTRACTOR personnel will reasonably cooperate with HHSC or other state or federal administrative agency personnel at no additional charge to HHSC for all purposes relating to the administration of HHSC Programs or this Agreement.

Section 8.06 ***Cooperation with other vendors and prospective vendors***

(a) *Supplemental Contracts*

HHSC may award supplemental contracts for work related to the Agreement, or any portion thereof.

(b) *Access*

At HHSC's request, CONTRACTOR will allow parties interested in responding to HHSC solicitations to have reasonable access during normal business hours to software, systems documentation, and site visits to the CONTRACTOR's facilities used by CONTRACTOR in the performance of its obligations under the Agreement. All such parties inspecting the facilities and software and systems documentation may be required to agree to use the information so obtained only in the State of Texas and only for the purpose of responding to the solicitation.

Section 8.07 ***Other Health and Human Services Agencies' participation in the Agreement***

In addition to providing the Services specified for HHSC, CONTRACTOR agrees to allow other Health and Human Service agencies the option to participate in the Agreement under the same terms and conditions. Each agency that elects to obtain services under this Section will issue a purchase order to CONTRACTOR, referring to, and incorporating by reference, the terms and conditions specified in the Agreement.

Section 8.08 ***Marketing***

CONTRACTOR must not use the name of HHSC, the State of Texas, or any other state agency, or refer to HHSC or any state agency directly or indirectly in any promotional or marketing materials, customer lists, or business presentations other than proposals or reports submitted to HHSC, an administrative agency of the State of Texas, or a governmental agency or unit of another state or the federal government without the consent of HHSC.

Section 8.09 ***Assignment and Assumption***

(a) Assignment by CONTRACTOR.

CONTRACTOR will not assign all or any portion of its rights under or interests in the Agreement or delegate any of its duties without prior written consent of HHSC, which will not be unreasonably withheld. Any written request for assignment or delegation must be accompanied by written acceptance of the assignment or delegation by the assignee or delegation by the delegate. Except where otherwise agreed in writing by HHSC, assignment or delegation will not release CONTRACTOR from its liability under the Agreement for any causes of action arising prior to the date of assignment.

(b) Assignment by HHSC.

CONTRACTOR understands and agrees HHSC may in one or more transactions assign, pledge, or transfer the Agreement. This assignment will only be made to another State agency or a non-state agency that is contracted to perform agency support.

(c) Assumption.

Each party to whom a transfer is made must assume all or any part of CONTRACTOR'S or HHSC's interests in the Agreement, the product, and any documents executed with respect to the Agreement, including, without limitation, the assignor's obligation for all or any portion of the purchase payments, in whole or in part.

Section 8.10 ***CONTRACTOR Personnel Management***

(a) Qualifications, retention and replacement of CONTRACTOR Employees

CONTRACTOR agrees to maintain the organizational and administrative capacity and capabilities to carry out all duties and responsibilities under the Agreement. The personnel CONTRACTOR assigns to perform the duties and responsibilities under the Agreement will be properly trained and qualified for the functions they are to perform. CONTRACTOR does not warrant the quality of training for which the State is responsible. Notwithstanding transfer or turnover of personnel, CONTRACTOR remains obligated to perform all duties and

responsibilities under the Agreement without degradation and in accordance with the terms of the Agreement.

(b) Responsibility for CONTRACTOR personnel.

(1) Employment and Agency

CONTRACTOR's Employees and Subcontractors will not in any sense be considered employees of HHSC or the State of Texas, but will be considered CONTRACTOR's Employees for all purposes. Except as provided in the Agreement, neither CONTRACTOR nor any of CONTRACTOR's Employees or Subcontractors may act in any sense as agents or representatives of HHSC or the State of Texas.

(2) E-Verify System

By entering into this Agreement, CONTRACTOR certifies and ensures that it utilizes and will continue to utilize, for the Term, the U.S. Department of Homeland Security's E-Verify system to determine the eligibility of:

1. All persons employed to perform duties within Texas, during the Term; and

2. All persons (including Subcontractors) assigned by CONTRACTOR to perform work pursuant to the Agreement, within the United States of America.

(3) Liability

CONTRACTOR's Employees must be paid exclusively by CONTRACTOR for all services performed. CONTRACTOR is responsible for and must comply with all requirements and obligations related to such Employees under local, state or federal law, including minimum wage, social security, unemployment insurance, state and federal income tax, and workers' compensation obligations. CONTRACTOR assumes sole and full responsibility for its acts and omissions and the acts and omissions of its personnel and Subcontractors.

CONTRACTOR AGREES THAT ANY CLAIM ON BEHALF OF ANY PERSON ARISING OUT OF EMPLOYMENT OR ALLEGED EMPLOYMENT (INCLUDING, BUT NOT LIMITED TO, CLAIMS OF DISCRIMINATION AGAINST CONTRACTOR, ITS OFFICERS, OR ITS AGENTS) ARE THE SOLE RESPONSIBILITY OF CONTRACTOR AND ARE NOT THE RESPONSIBILITY OF HHSC (UNLESS HHSC, ITS AGENTS, VENDORS OR EMPLOYEES WERE THE PROXIMATE CAUSE OF SUCH CLAIMS), AND THAT CONTRACTOR WILL INDEMNIFY AND HOLD HARMLESS THE STATE FROM ANY AND ALL SUCH CLAIMS ASSERTED AGAINST THE STATE.

CONTRACTOR understands that any person who alleges a claim arising out of employment or alleged employment by CONTRACTOR will not be entitled to any compensation, rights, or benefits from HHSC (including, but not limited to, tenure rights, medical and hospital care, sick and annual/vacation leave, severance pay, or retirement benefits).

(c) Conduct of and responsibility for CONTRACTOR personnel.

CONTRACTOR's personnel will at all times comply with applicable Agreement terms, state and federal rules, regulations, HHSC's policies provided to CONTRACTOR, and HHSC's requests regarding personal and professional conduct; and otherwise conduct

themselves in a businesslike and professional manner. If HHSC determines in good faith that a particular Employee or Subcontractor is not conducting himself or herself in accordance with the Agreement, HHSC may provide CONTRACTOR with notice and documentation concerning such conduct. Upon receipt of such notice, CONTRACTOR must promptly investigate the matter and take appropriate action that may include:

(1) Removing the Employee from the project;

(2) Providing HHSC with written notice of such removal; and

(3) Replacing the Employee with a similarly qualified individual acceptable to HHSC.

Nothing in the Agreement will prevent CONTRACTOR, at the request of HHSC, from replacing any personnel who are not adequately performing their assigned responsibilities or who, in the reasonable opinion of HHSC's Project Director, after consultation with CONTRACTOR, are unable to work effectively with the members of the HHSC's staff. In such event, CONTRACTOR will provide replacement personnel with equal or greater skills and qualifications as soon as reasonably practicable. Replacement of Key Personnel will be subject to HHSC review and approval. The Parties will work together in the event of any such required replacement so as not to disrupt the overall project schedule.

CONTRACTOR agrees that anyone employed by CONTRACTOR to fulfill the terms of the Agreement is an Employee of CONTRACTOR and remains under CONTRACTOR's sole direction and control.

CONTRACTOR agrees to be responsible for the following with respect to its Employees:

(1) Any and all employment taxes or other payroll withholding;

(2) Damages caused by CONTRACTOR's Employees acting within or outside the scope of their duties under the Agreement; and

(3) Determination of the hours to be worked and the duties to be performed by CONTRACTOR's Employees.

CONTRACTOR agrees and will inform its Employees and Subcontractor(s) that there is no right of action against HHSC for any duty owed by CONTRACTOR under the Agreement. CONTRACTOR understands that HHSC does not assume liability for the actions of, or judgments rendered against, the CONTRACTOR, its Employees, agents or Subcontractors. CONTRACTOR agrees that it has no right to indemnification or contribution from HHSC for any judgments rendered against CONTRACTOR or its Subcontractors. HHSC's liability to the CONTRACTOR's Employees, agents and Subcontractors, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code § 101.001 et seq.).

(d) Standards of Conduct

In accordance with 1 TAC 391.505(a), CONTRACTOR and its Subcontractors must implement standards of conduct for their own personnel and agents on terms at least as restrictive as those applicable to HHSC contracting personnel. These standards must adhere to ethics requirements adopted in rule, in addition to any ethics policy, or code of ethics approved by the Executive Commissioner of HHSC.

Section 8.11 ***Responsibility for Subcontractors***

CONTRACTOR remains fully responsible for obligations, services, and functions performed by its Subcontractors to the same extent as if such obligations, services, and functions were performed by CONTRACTOR's Employees, and for purposes of the Agreement such work will be deemed work performed by CONTRACTOR. HHSC reserves the right to require the replacement of any Subcontractor found by HHSC to be unacceptable. CONTRACTOR will assume responsibility for all contractual responsibilities whether or not the CONTRACTOR performs them. Further, HHSC considers the CONTRACTOR to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the Agreement.

CONTRACTOR must not disclose Confidential Information of HHSC or the State of Texas to a Subcontractor unless and until such Subcontractor has agreed in writing to protect the confidentiality of such Confidential Information in the manner required of CONTRACTOR under the Agreement.

Upon HHSC advance request, CONTRACTOR must submit a copy of Subcontracts with a value greater than $100,000.00 for a Subcontractor that was not identified to HHSC prior to the Effective Date to HHSC for HHSC's review. During this review, HHSC reserves the right, as reasonable, to: (1) reject the agreement or require changes to any provisions that do not comply with the requirements or duties and responsibilities of the Agreement or create significant barriers for HHSC in monitoring compliance with the Agreement; (2) object to the selection of the Subcontractor; or (3) object to the subcontracting of the Services and Deliverables proposed to be subcontracted.

CONTRACTOR may not limit or restrict, through a covenant not to compete, employment agreement or other contractual arrangement, HHSC's ability to contract with Subcontractors or former Employees of the CONTRACTOR.

CONTRACTOR must include the applicable provisions of this Agreement in all subcontracts based on the scope and magnitude of work to be performed by such Subcontractor, and the terms "Agreement," "CONTRACTOR" and any other term necessary will be modified appropriately to preserve the State's rights.

Section 8.12 ***Electronic and Information Resources Accessibility Standards***

All technological solutions provided by the CONTRACTOR must meet federal and state, including Texas Administrative Code Chapters 206 and 213, Texas Government Code Chapter 2054, accessibility standards for persons with disabilities. CONTRACTOR specifically agrees to adhere to State Electronic and Information Resources (EIR) Accessibility Standards to the extent CONTRACTOR performs Services or provides Deliverables that include EIR that HHSC employees or members of the public are required or permitted to access. Nothing in this Section is intended to prescribe the use of particular designs or technologies or to prevent the use of alternative technologies, provided they result in substantially equivalent or greater access to and use of a product. For avoidance of doubt, HHSC retains the responsibility to interpret the applicable Accessibility Standards with respect to its employees and clients and shall establish the accommodations that will apply to meet the requirements thereof. This Section does not apply to incidental uses of EIR in the performance of the Agreement, unless the Parties agree that the EIR will become property of

the State of Texas or will be used by HHSC's clients or recipients after completion of the Agreement.

Section 8.13 ***Audit and Financial Compliance***

CONTRACTOR must maintain, and require its Subcontractors to maintain, supporting information and documents that are adequate to ensure that payments are made and Services are properly performed in accordance with applicable federal and state requirements, and are sufficient to ensure the accuracy and validity of CONTRACTOR invoices. These documents, including all original claims forms, will be maintained and retained by CONTRACTOR or its Subcontractors in accordance with Section 8.21 or until the resolution of all litigation, claim, financial management review or audit pertaining to the Agreement, whichever is longer. CONTRACTOR agrees to timely repay any undisputed audit exceptions taken by HHSC in any audit of the Agreement. In the event of conflict, the specific requirements in the Functional Requirements and Key Measures control.

Upon reasonable notice, CONTRACTOR must provide, and cause its Subcontractors to provide, the officials and entities identified by the State with prompt, reasonable, and adequate access to any records, books, documents, and papers that are directly pertinent to the performance of the Agreement. CONTRACTOR agrees to provide the access described wherever CONTRACTOR maintains these books, records, and supporting documentation. CONTRACTOR further agrees to provide such access in reasonable comfort and to provide any furnishings, equipment, or other conveniences deemed reasonably necessary to fulfill the purposes described in this Section. CONTRACTOR will require its Subcontractors to provide comparable access and accommodations. Upon reasonable request, CONTRACTOR must provide copies of the information described in this Section free of charge to HHSC and the entities designated by HHSC.

The access described in this Section specifically includes, for CONTRACTOR and its Subcontractors, access to service locations, facilities, or installations, software and equipment, financial records, and other records. CONTRACTOR must provide as part of the Services any assistance that such auditors and inspectors reasonably may require to complete such audits or inspections.

CONTRACTOR must take action to ensure its or a Subcontractor's compliance with or correction of any finding of noncompliance with any law, regulation, audit requirement, or generally accepted accounting principle relating to such entity's performance of the Services and Deliverables or any other deficiency contained in any audit, review, or inspection conducted under the Agreement that reveals a non-compliance with the terms of this Agreement. This action will include CONTRACTOR'S delivery to HHSC, for HHSC'S approval, a Corrective Action Plan that addresses deficiencies identified in any audit(s), review(s), or inspection(s) within thirty (30) calendar days of the close of the audit(s), review(s), or inspection(s). CONTRACTOR will bear the expense of compliance with any finding of noncompliance under the Agreement that is caused by CONTRACTOR.

Texas Health and Safety Code Section 32.0705 directs HHSC to contract with an independent auditor to perform annual independent external financial and performance audits of any Medicaid contractor used by HHSC in HHSC's operation of a part of the state Medicaid program. "Medicaid contractor" means an entity that, under a contract with or otherwise on

behalf of HHSC, performs one or more administrative services in relation to HHSC's operation of a part of the state Medicaid program, such as claims processing, utilization review, client enrollment, provider enrollment, quality monitoring, or payment of claims. The independent auditor will deliver to the CONTRACTOR and to HHSC a report of the findings and recommendations within 30 calendar days of the close of each audit. The report will be prepared in accordance with generally accepted auditing standards.

CONTRACTOR understands and agrees that the auditor will also request that CONTRACTOR's management confirm certain representations made to the auditor during the audit. The responses to those inquiries, and the related written representations of management required by generally accepted auditing standards, are part of the evidential matter that the auditor will rely on in forming its opinion on the CONTRACTOR'S financial statements and reports.

Nothing in this Section shall compel CONTRACTOR to perform any services at no cost that would have otherwise required an Amendment to the Agreement pursuant to Article 9 .

Section 8.14 ***Set-Off***

With respect to any undisputed amount that a Party in good faith determines should be reimbursed to it or is otherwise payable to it by the other Party under the Agreement, the Party seeking the set-off may deduct the entire amount owed against the charges otherwise payable or expenses owed to it under the Agreement until such time as the entire amount determined to be owed has been paid.

HHSC will be relieved of its obligation to make any payments to the CONTRACTOR until such time as all such amounts have been credited to HHSC and the CONTRACTOR will be relieved of its obligation to make any payments to HHSC until such time as such amounts have been credited to the CONTRACTOR.

If HHSC reasonably disputes payment of all or any portion of an invoice from the CONTRACTOR, HHSC will notify the CONTRACTOR of the dispute and both Parties will attempt in good faith to resolve the dispute. HHSC will not be required to pay any disputed portion of a CONTRACTOR invoice until the dispute is resolved, so long as it continues to pay all undisputed amounts and fees for compliant work. If HHSC has withheld payment for three (3) consecutive months, the Parties will evaluate the impact of additional withholding on CONTRACTOR's operating expenses and the need to fund the performance of the Services. If additional withholdings would reasonably result in a risk to performance or significant hardship to CONTRACTOR, then HHSC shall thereafter pay amounts as appropriate in light of the evaluated risk or significant hardship, but may continue to withhold the previously withheld amounts until CONTRACTOR remedies the nonperformance or, in the event of a dispute, such dispute is resolved. Notwithstanding any such dispute, the CONTRACTOR must continue to perform the Services and produce Deliverables in compliance with the terms of the Agreement pending resolution of such dispute so long as all undisputed amounts and fees for compliant work continue to be paid to CONTRACTOR.

Section 8.15 ***Dispute Resolution***

(a) *General Agreement of the Parties*

The Parties mutually agree that the interests of fairness, efficiency, and good business practices are best served when the Parties employ all reasonable and informal means to resolve any dispute under the Agreement. The Parties express their mutual commitment to using all reasonable and informal means of resolving disputes prior to invoking a remedy provided elsewhere in this Section.

(b) *Duty to Negotiate in Good Faith*

Any dispute that in the judgment of any Party to this Agreement may materially or substantially affect the performance of any Party will be reduced to writing and delivered to the other Party. The Parties must then negotiate in good faith and use every reasonable effort to resolve such dispute and the Parties shall not resort to any formal proceedings unless they have reasonably determined that a negotiated resolution is not possible and notified the other Party. The resolution of any dispute disposed of by agreement between the Parties shall be reduced to writing and delivered to all Parties within ten (10) business days of such resolution.

(c) *Claims for Breach of Agreement*

As required by Chapter 2260, Government Code, CONTRACTOR's claim for breach of this Agreement must be resolved in accordance with the dispute resolution process established by HHSC in accordance with Chapter 2260, Government Code.

The Parties expressly agree that the CONTRACTOR's claim for breach of this Agreement that the Parties cannot resolve in the ordinary course of business or through the use of all reasonable and informal means will be submitted to the negotiation process provided in Chapter 2260, Subchapter B, Government Code.

1. To initiate the process, CONTRACTOR must submit written notice to HHSC that specifically states that CONTRACTOR invokes the provisions of Chapter 2260, Subchapter B, Government Code. The notice must comply with the requirements of Title 1, Chapter 392, Subchapter B of the Texas Administrative Code.

2. The Parties expressly agree that the CONTRACTOR's compliance with Chapter 2260, Subchapter B, Government Code, will be a condition precedent to the filing of a contested case proceeding under Chapter 2260, Subchapter C, of the Government Code.

(d) *Contested Case Proceedings*

The contested case process provided in Chapter 2260, Subchapter C, Government Code, will be CONTRACTOR's sole and exclusive process for seeking a remedy for any and all alleged breaches of contract by HHSC if the Parties are unable to resolve their disputes under this Section.

1. The Parties expressly agree that compliance with the contested case process provided in Chapter 2260, Subchapter C, Government Code, will be a condition precedent to seeking consent to sue from the Texas Legislature under Chapter 107, Civil Practices & Remedies Code. Neither the execution of this Agreement by HHSC nor any other conduct

of any representative of HHSC relating to this Agreement shall be considered a waiver of the State's sovereign immunity to suit.

2. The submission, processing and resolution of CONTRACTOR's claim is governed by the rules adopted by HHSC pursuant to Chapter 2260, Government Code, found at Title 1, Chapter 392, Subchapter B of the Texas Administrative Code.

Section 8.16 ***Preferences under service contracts***

CONTRACTOR is required in performing the Agreement to purchase products and materials produced in the State of Texas when they are available at a price and time comparable to products and materials produced outside the state.

Section 8.17 ***Taxes***

Except as permitted for Pass-Through Expenses, HHSC is not responsible in any way for the payment of any federal, state or local taxes (other than hotel, airline and sales taxes expended specifically for the Agreement) related to or incurred in connection with the CONTRACTOR'S performance of the Agreement. CONTRACTOR must pay and discharge any and all such taxes, including any penalties and interest. In addition, HHSC is exempt from Federal excise taxes, and will not pay for any personal property taxes or income taxes levied on CONTRACTOR or on any taxes levied on Employee wages. Within ten (10) business days of the Effective Date, HHSC will provide CONTRACTOR with a copy of its applicable tax exemption certificate.

Section 8.18 ***Independence of CONTRACTOR***

CONTRACTOR will perform work under the Agreement as an independent contractor and not as agent or representative of HHSC. CONTRACTOR is solely and exclusively liable for all taxes and employment-related charges incurred in connection with the performance of the Agreement. HHSC will not be liable for any employment-related charges or benefits of CONTRACTOR, such as workers compensation benefits, unemployment insurance and benefits, or fringe benefits.

Section 8.19 ***No Additional Consideration***

Except as explicitly set forth herein, CONTRACTOR will not be entitled to nor receive from HHSC any additional consideration, compensation, salary, wages, or any other type of remuneration for services rendered under the Agreement. CONTRACTOR will not be entitled by virtue of the Agreement to consideration in the form of overtime, health insurance benefits, retirement benefits, disability retirement benefits, sick leave, vacation time, paid holidays, or other paid leaves of absence of any type or kind whatsoever. In addition, the costs associated with transportation, delivery, and insurance (except insurance cost relating to coverage for the HHSC-owned capital equipment reflected in the Fees described in Article 6) relating to the CONTRACTOR'S performance of the Agreement will be paid for by the CONTRACTOR.

Section 8.20 ***Anti – Recruitment***

CONTRACTOR has not retained or promised to retain any person or company, or utilized or promised to utilize a consultant that participated in HHSC's development of

specific criteria of the Agreement or who participated in the selection of the CONTRACTOR for the Agreement.

CONTRACTOR will not recruit or employ any HHSC professional or technical personnel who have worked on projects relating to the subject matter of the Agreement, or who have had any influence on decisions affecting the subject matter of the Agreement, for two (2) years following the completion of the Agreement.

Section 8.21 ***Record Retention***

HHSC's Record Retention Schedule is incorporated by reference as if set forth herein, and applicable to this Agreement.

For the avoidance of doubt, and notwithstanding the foregoing paragraph, CONTRACTOR shall retain, and retrieve upon HHSC request, all Prior Authorization (PA) records during the Term, including those of the predecessor contract #529-14-0125-00003 between HHSC and CONTRACTOR. The PA records include, in any format, but are not limited to, all current, stored and archived document inventory, internal and external correspondence of any kind, claims and supporting documentation of any kind, including diagnostics, requests, reports, forms, tools, photographs, research, claims information, all PA information and processes, determinations of any kind, all memorandum regarding the PA requests. Upon the expiration or termination of this Agreement, CONTRACTOR shall provide the PA records to HHSC.

Section 8.22 ***Confidentiality***

During the course of the Agreement each Party may disclose Confidential Information to the other. CONTRACTOR's obligations with respect to HHSC's Confidential Information are set forth in the Data Use Agreement attached hereto as Exhibit A. HHSC shall not disclose CONTRACTOR's Confidential Information to any third party except as necessary to comply with Texas Open Record Statutes or as otherwise required by law, and shall use the same standards of care as it does to protect its own Confidential Information, but no less than a reasonable standard of care. Unauthorized disclosure of Confidential Information shall be a material breach of this Agreement.

CONTRACTOR agrees that any consultant reports received by HHSC in connection with the Agreement may be distributed by HHSC, in its discretion, to any other state agency and the Texas legislature. Any distribution may include posting on HHSC's website or the website of a standing committee of the Texas Legislature. If such reports would be damaging to CONTRACTOR's reputation, CONTRACTOR shall be afforded the opportunity to provide an additional report to be distributed along with the original report.

Article 9. Amendments, Modifications, And Change Order Requests

Section 9.01 ***Expectations and Understandings***

The Parties may amend this Agreement by mutual written agreement. Changes in the contracted Services or Deliverables must be authorized in accordance with this Article. No different or additional services, work, or products will be authorized or performed except

under an amendment or modification of the Agreement that is executed in compliance with this Article. No waiver of any term, covenant, or condition of the Agreement will be valid unless executed in compliance with this Article. CONTRACTOR will not be obligated to perform, nor be entitled to payment, for any services, work or products that are not authorized by a properly executed Agreement amendment or modification, or through the express authorization of both Parties.

Section 9.02 ***Business Plan for Change Orders and Amendments***

This Section 9.02 represents the Parties' Business Plan for negotiating amendments and modifications to the Agreement, which may include new services that are related to the Services or changes to the Services. For purposes of this section, "no additional cost" means that CONTRACTOR will not charge additional time or resources beyond the work performed by existing resources, which time will be an Allowable Cost as defined in Exhibit C.

(a) Formal Amendment Procedure.

Except as provided below, all modifications to the Agreement must be accomplished through the formal amendment process set forth herein.

(1) HHSC or CONTRACTOR may propose changes in the services, deliverables, or other aspects of this Agreement.

(2) If HHSC proposes a change, it will deliver a written notice to CONTRACTOR describing the proposed change. CONTRACTOR must prepare a response, at no additional cost to HHSC, within thirty (30) calendar days or a shorter period as mutually agreed. The response must specify:

(A) The effect, if any, of the proposed change on the amounts payable by HHSC under this Agreement and the manner used to calculate such effect;

(B) The effect, if any, of the proposed changes on CONTRACTOR's performance of its obligations under this Agreement, including the effect on the services or deliverables;

(C) The anticipated time schedule for implementing the proposed changes; and

(D) Any other information requested by HHSC or reasonably necessary for HHSC to make an informed decision regarding the proposal.

(3) If CONTRACTOR desires to propose a change, it must deliver a change request to HHSC that includes the information described in Section 9.02(a)(2) above.

(4) If HHSC accepts CONTRACTOR's proposal or change request, the Parties will execute an amendment to this Agreement. The amendment must be signed by HHSC's Executive Commissioner or his designee and a duly authorized CONTRACTOR representative.

(b) Modification of Project Plans and Minor Administrative Changes

(1) HHSC's Project Sponsor is authorized to provide written approval of mutually agreed upon Minor Administrative Changes to the Services and Deliverables described herein that do not increase the Fees or term. Changes that increase the Fees or term must be accomplished through HHSC's formal amendment procedure, as set forth in Section 9.02(a) above.

(2) Upon approval of a Minor Administrative Change, HHSC's Project Sponsor will provide CONTRACTOR with written notice the change has been accepted. Both Parties must maintain copies of such notices with their contract files.

(c) CONTRACTOR Rates

When CONTRACTOR provides pricing estimates for any modifications to the Agreement, such pricing shall be based off of the CONTRACTOR Rates and the Parties will mutually agree on the final price that will apply in the applicable Amendment.

Section 9.03 ***Changes in Law***

The Statement of Work in this Agreement applies to the operational capabilities and system processing capabilities as of the Effective Date of this Agreement. In the event of a change in laws, regulations, policies, procedures, orders, rulings, or findings, whether by the State or Federal governmental bodies, that are applicable to the Services ("Applicable Law"), or HHSC interpretation of Applicable Law that impacts the cost or timing of delivering the Services, the Parties will follow the process described herein to modify the Statement of Work, project schedule, and if applicable, price as necessary to meet the requirements of such change.

Article 10. REMEDIES

Section 10.01 ***Tailored Remedies***

CONTRACTOR agrees and understands that HHSC may pursue tailored contractual remedies for noncompliance with the Agreement. At any time and at its discretion, HHSC may impose or pursue one or more remedies for each item of noncompliance and will determine remedies on a case-by-case basis. Except for claims for liquidated damages, HHSC's pursuit or non-pursuit of a tailored remedy does not constitute a waiver of any other remedy that HHSC may have at law or equity.

Section 10.02 ***Equitable Remedies***

CONTRACTOR acknowledges that, if CONTRACTOR breaches (or attempts or threatens to breach) its obligation under the Agreement, the State will be irreparably harmed. In such a circumstance, HHSC may proceed directly to court. If a court of competent jurisdiction finds that CONTRACTOR breached (or attempted or threatened) to breach any such obligations, CONTRACTOR agrees that without any additional findings of irreparable injury or other conditions to injunctive relief, it will not oppose the entry of an appropriate order compelling performance by CONTRACTOR and restraining it from any further breaches (or attempted or threatened breaches), subject to the continued obligation of HHSC to make payment for such Services as CONTRACTOR continues to perform for HHSC following the applicable court order.

Section 10.03 ***Liquidated Damages***

The Key Measures in the Statement of Work are of a level of criticality that a failure to meet them will result in harm to HHSC. In the event that any such Key Measures are not met,

HHSC may elect to assess designated liquidated damages subject to the provisions of this Section.

(a) *Assessment of Liquidate Damages – Proportional Responsibility*

Prior to the assessment of any liquidated damages, the Parties will jointly conduct a root cause analysis to determine the cause of the delay or failure. Liquidated damages may not be assessed when the applicable failure was primarily caused by HHSC. It is the intent of the Parties that the amount of any assessed liquidated damages fairly and equitably represent the proportional responsibility of the Parties.

(b) *CONTRACTOR Corrective Action Plan*

Each time that CONTRACTOR causes a Key Measure to be missed and upon HHSC request, CONTRACTOR will propose to HHSC a plan to remedy such failure and avoid its reoccurrence ("Corrective Action Plan" or "CAP"). In evaluating whether to assess liquidated damages HHSC will reasonably consider the quality of the CAP, CONTRACTOR's efforts to remediate impacts of the Key Measure failure and the extent of any actual harm suffered by HHSC.

(c) *CONTRACTOR Liability Maximum*

The total amount of liquidated damages that may be assessed in any calendar month may not exceed 10% of the total Fees payable to CONTRACTOR in such month.

(d) *CONTRACTOR Liability for Failure of Multiple Key Measures*

HHSC shall be entitled to any liquidated damage that results from a single breach that causes the failure of multiple Key Measures for only those Key Measures that are designated as "Tier 1." For all other instances where a single breach causes the failure of multiple Key Measures, HHSC may only assess the liquidated damages associated with one Key Measure.

(e) *Remedies Other Than Liquidated Damages*

The parties acknowledge that the liquidated damages described herein are not intended to be in the nature of a penalty, but rather an approximation of damages to HHSC that would otherwise be difficult to quantify. As such, HHSC acknowledges that if it elects to assess liquidated damages as permitted hereunder, such credits shall constitute the sole and exclusive remedy for the applicable Key Measure, except that HHSC shall retain the right to terminate this Agreement for material breach if CONTRACTOR misses the same Key Measure subject to liquidated damages for more than three (3) consecutive months. Notwithstanding the foregoing, nothing in this Section shall be read to require HHSC to assess any liquidated remedies in lieu of other remedies available to HHSC at law, at equity or under this Agreement.

(f) *Key Measure Assessment Clarification*

For the avoidance of doubt, liability for liquidated damages associated with a Key Measure shall only commence after the effective date of such Key Measure. The Parties acknowledge that some Key Measures are evaluated against data from the prior month in which the applicable Services were performed by CONTRACTOR (the "Service Month"), while others may be evaluated against data two months prior (i.e. accuracy measures that require QA review). By way of example, if a Key Measure has an effective date of September 1, then the Service Month is

September. The September Key Measure report delivered in October would include measurement data for some Key Measure with a Service Month of August and some Key Measure with a Service Month of September. There would be liability for Key Measure failures in the Service Month of September, but not for the Service Month of August.

Article 11. TERMINATION

Section 11.01 *Termination of the Agreement*

HHSC may terminate this Agreement, in whole or in part, if CONTRACTOR's performance is not materially compliant and such deficiency is not cured within thirty (30) calendar days of notice thereof; provided however, nothing in this provision shall restrict the State's right to exercise any remedy without restriction to address a serious threat to health and safety. The Parties may also mutually agree to terminate this Agreement. Notwithstanding the foregoing, neither termination nor expiration of this Agreement shall reduce or diminish CONTRACTOR's obligation to perform the Services for up to one year from the date of any termination or expiration of the Agreement as turnover services. HHSC expressly reserves the right to terminate the Agreement for its convenience upon sixty (60) days advance written notice when it is in HHSC or the State's best interest to do so, or for non-appropriation of funds.

In the event that the Agreement is terminated for any reason, or upon its expiration, HHSC will, at HHSC's discretion, retain ownership of any and all associated work products, Deliverables or documentation for any Custom Software in whatever form they exist.

Section 11.02 *Payment at Termination*

In the event of termination of this Agreement, within 15 calendar days of the termination date CONTRACTOR shall invoice for all Services provided prior to the termination date. If HHSC terminates the Agreement for CONTRACTOR's material breach, HHSC will pay CONTRACTOR on the effective date of termination (or as soon as possible thereafter taking into account appropriation and fund accounting requirements) any undisputed amounts due for all completed, approved, and accepted Services or Deliverables, less any payment holds or offsets permitted under this Agreement. If HHSC terminates the Agreement for its convenience, HHSC will pay CONTRACTOR on the effective date of termination (or as soon as possible thereafter taking into account appropriation and fund accounting requirements) in addition to Fees for work performed prior to the termination date, any substantiated demobilization or stranded costs of CONTRACTOR resulting from such termination. The Parties agree to negotiate in good faith to resolve any other issues.

If HHSC terminates the Agreement for CONTRACTOR's material breach, the CONTRACTOR will be responsible to HHSC for all cover costs incurred by HHSC, the State of Texas, or any of its administrative agencies to replace the CONTRACTOR. These costs include, but are not limited to, the costs of procuring a substitute vendor.

If HHSC terminates the Agreement as a result of the Modernization Activities described in Section 4.07, HHSC will pay CONTRACTOR on the effective date of such action (or as soon as possible thereafter taking into account appropriation and fund accounting requirements) in addition to Fees for work performed prior to such date, any substantiated

demobilization or stranded costs of CONTRACTOR resulting from the termination. In the case of a modification as a result of the Modernization Activities, the Parties will follow an agreed payment schedule for any of the costs set forth herein. The Parties agree to negotiate in good faith to resolve any other issues, including how any modifications to the Services impact the Fees.

Section 11.03 ***Express Survivability***

CONTRACTOR agrees that any necessary obligations that by their nature cannot be completed prior to any termination date will survive and CONTRACTOR will remain obligated to perform such obligations and Services to assure successful turnover to a subsequent vendor or the State pursuant to the State approved Turnover Plan which may be requested at any time during the Term. During such period, CONTRACTOR must provide HHSC access to records, facilities, documentation, and information required to close out the Services under the Agreement. Such assistance expressly includes providing any assistance reasonably necessary to enable HHSC or its designee to close out the Agreement and move the work to another vendor or to perform the work itself. This assistance also includes taking any steps necessary to grant or transfer any software licenses, subject to applicable third party software license agreements. HHSC shall pay for the turnover of services described in this Section and any Services that CONTRACTOR continues to perform, but shall not be required to pay for additional costs resulting from a material breach by CONTRACTOR that increase the amount for which HHSC would otherwise be responsible.

Article 12. Representations and Warranties

Section 12.01 ***Workmanship and Performance***

CONTRACTOR represents and warrants that it will perform all Services and provide all Deliverables in a good and workmanlike manner.

Section 12.02 ***Warranty of Deliverables***

CONTRACTOR represents and warrants that upon delivery of a Deliverable, it will materially comply with the applicable DED. CONTRACTOR assigns to HHSC all of the manufacturers' warranties and indemnities relating to all products, including without limitation, third party software to the extent CONTRACTOR is permitted by the manufacturers to make such assignments to HHSC. Such assignment is subject to all of the terms and conditions imposed by the manufacturers with respect thereto.

CONTRACTOR assigns to HHSC all of the manufacturers' warranties and indemnities relating to all products, including without limitation, Third Party Software to the extent CONTRACTOR is permitted by the manufacturers to make such assignments to HHSC. Such assignment is subject to all of the terms and conditions imposed by the manufacturers with respect thereto.

Section 12.03 ***Warranty Repairs***

The Parties acknowledge that the scope and pricing for Services includes the resolution of system defects, including warranty claims, as detailed in the maintenance Functional Requirements set forth in Exhibit "B".

Section 12.04 ***Disclaimer of Implied Warranties***

THE WARRANTIES SET FORTH IN THIS AGREEMENT ARE CONTRACTOR'S SOLE WARRANTIES AND ALL IMPLIED WARRANTIES ARE EXPRESSLY DISCLAIMED.

Section 12.05 ***Assurances and Certifications***

CONTRACTOR acknowledges its continuing obligation to comply with the requirements of any certifications contained in the Agreement, and will immediately notify HHSC of any changes in circumstances affecting those certifications.

Section 12.06 ***Conflicts of Interest***

CONTRACTOR agrees to comply with applicable state and federal laws, rules, and regulations regarding conflicts of interest in the performance of its duties under the Agreement. CONTRACTOR warrants that it has no interest and, unless otherwise disclosed to HHSC as described herein, will not acquire any direct or indirect interest that would conflict in any manner or degree with its performance under the Agreement. Notwithstanding the foregoing, HHSC acknowledges that CONTRACTOR's corporate affiliates perform various services for numerous pharmaceutical, pharmacy benefit managers, commercial payers and healthcare providers in the State of Texas and that, subject to the safeguards established below, such commercial services are not, in and of themselves, a conflict of interest for CONTRACTOR under this Agreement.

CONTRACTOR will establish reasonable safeguards to prohibit its Employees from using their positions for a purpose that constitutes or presents an actual or apparent personal or organizational conflict of interest for CONTRACTOR under this Agreement. CONTRACTOR will operate with complete independence and objectivity without actual conflict of interest with respect to the activities conducted under the Agreement with the State of Texas.

Except as acknowledged above or otherwise disclosed and approved by HHSC prior to the Effective Date of the Agreement, CONTRACTOR warrants that, as of the Effective Date and to the best of its knowledge and belief, there are no relevant facts or circumstances that could give rise to organizational conflict of interest for CONTRACTOR affecting the Agreement. CONTRACTOR affirms that it has neither given, nor intends to give, at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, at any time during the procurement process or in connection with the procurement process except as allowed under relevant state and federal law.

CONTRACTOR agrees that, if after the Effective Date, CONTRACTOR discovers or is made aware of an organizational conflict of interest under this Agreement, CONTRACTOR will immediately and fully disclose such interest in writing to the HHSC Project Director. In addition, CONTRACTOR must promptly disclose any relationship that might be perceived or represented as a conflict after its discovery by CONTRACTOR or by HHSC as a potential conflict. HHSC reserves the right to make a final determination regarding the existence of conflicts of interest, and CONTRACTOR agrees to abide by HHSC's decision.

Section 12.07 ***Anti-kickback and Anti-Trust***

CONTRACTOR certifies that it will comply with the Anti-Kickback Act of 1986, 41 USC §51-58 and Federal Acquisition Regulation 52.203-7. CONTRACTOR further certifies that neither CONTRACTOR, nor the person represented by the CONTRACTOR, nor any person acting for the represented person has violated the antitrust laws codified by Chapter 15, Business & Commerce Code, or the federal antitrust laws; or directly or indirectly communicated the bid/offer associated with this contract to a competitor or other person engaged in the same line of business. CONTRACTOR assigns to HHSC all of CONTRACTOR's rights, title, and interest in and to all claims and causes of action CONTRACTOR may have under the antitrust laws of Texas or the United States for overcharges associated with this Agreement.

Section 12.08 ***Debt or Back Taxes***

In accordance with Section 403.055 of the Government Code, CONTRACTOR agrees that any payments due to CONTRACTOR under the Agreement will be first applied toward any debt or back taxes CONTRACTOR owes the State of Texas. CONTRACTOR further agrees that payments will be so applied until such debts and back taxes are paid in full.

CONTRACTOR certifies that it is not presently indebted to the State of Texas, and that CONTRACTOR is not subject to an outstanding judgment in a suit by the State of Texas against CONTRACTOR for collection of the balance. For purposes of this Section, an indebtedness is any amount sum of money that is due and owing to the State of Texas and is not currently under dispute. A false statement regarding CONTRACTOR's status will be treated as a material breach of the Agreement and may be grounds for termination at the option of HHSC.

Section 12.09 ***License, Certificates and Permits***

CONTRACTOR will obtain and maintain all licenses, certifications, permits, and authorizations necessary to perform the Services under the Agreement and currently is in good standing with all regulatory agencies that regulate any or all aspects of CONTRACTOR's performance of the Agreement. CONTRACTOR will maintain all required certifications, licenses, permits, and authorizations during the term of the Agreement and will use qualified and Texas licensed clinical personnel acting within their scope of practice where required to perform the Services. For any licensure needs that would be required outside the State of Texas, the Parties acknowledge that such circumstances would be addressed on a case-by-case basis and CONTRACTOR shall act promptly to secure such licenses as needed. CONTRACTOR certifies it is not ineligible to enter into this Agreement due to a failure to hold or maintain a license, permit or certificate required to meet its obligations under this Agreement.

The Parties agree that CONTRACTOR is not obligated to provide any debt in default services to HHSC. "Debt in default" is defined as amounts that remain due and outstanding after CONTRACTOR has fulfilled its collection obligations pursuant to the Functional Requirements and the corresponding HHSC procedures and instructions. The Parties agree that the Services and Deliverables do not constitute the collection of consumer debt.

Article IX, Section 163 of the General Appropriations Act for the 1998/1999 state fiscal biennium prohibits an agency that receives an appropriation under either Article II or V of the

General Appropriations Act from awarding an Agreement with the owner, operator, or administrator of a facility that has had a license, certificate, or permit revoked by another Article II or V agency. CONTRACTOR certifies it is not ineligible for an award under this provision.

Article 13. LIABILITY

Section 13.01 ***CONTRACTOR's Indemnity***

CONTRACTOR MUST, AT THE CONTRACTOR'S OWN EXPENSE, DEFEND WITH COUNSEL APPROVED BY THE STATE, INDEMNIFY, AND HOLD HARMLESS THE STATE AND STATE EMPLOYEES, OFFICERS, DIRECTORS, CONTRACTORS AND AGENTS FROM AND AGAINST ANY LOSSES, LIABILITIES, DAMAGES, PENALTIES, COSTS, FEES, INCLUDING WITHOUT LIMITATION REASONABLE ATTORNEYS' FEES, AND EXPENSES FROM ANY THIRD PARTY CLAIM OR ACTION FOR PROPERTY DAMAGE TO REAL OR TANGIBLE PROPERTY, BODILY INJURY OR DEATH, TO THE EXTENT CAUSED BY OR ARISING FROM THE NEGLIGENCE OR INTENTIONAL MISCONDUCT OF THE CONTRACTOR AND ITS EMPLOYEES, OFFICERS, AGENTS, OR SUBCONTRACTORS.

Section 13.02 ***Intellectual Property Infringement***

CONTRACTOR warrants that all Deliverables provided by CONTRACTOR will not infringe or misappropriate any right of, and will be free of any claim of, any third person or entity based on copyright, patent, trade secret, or other intellectual property rights.

CONTRACTOR WILL, AT ITS EXPENSE, DEFEND WITH COUNSEL APPROVED BY HHSC, INDEMNIFY, AND HOLD HARMLESS HHSC, ITS EMPLOYEES, OFFICERS, DIRECTORS, CONTRACTORS, AND AGENTS FROM AND AGAINST ANY LOSSES, LIABILITIES, DAMAGES, PENALTIES, COSTS, FEES, INCLUDING WITHOUT LIMITATION REASONABLE ATTORNEYS' FEES AND EXPENSES, FROM ANY CLAIM OR ACTION AGAINST HHSC THAT IS BASED ON A CLAIM OF BREACH OF THE WARRANTY SET FORTH IN THE PRECEDING PARAGRAPH. HHSC WILL PROMPTLY NOTIFY CONTRACTOR IN WRITING OF THE CLAIM, PROVIDE CONTRACTOR A COPY OF ALL INFORMATION RECEIVED BY HHSC WITH RESPECT TO THE CLAIM, AND COOPERATE WITH CONTRACTOR IN DEFENDING OR SETTLING THE CLAIM.

In case the Deliverables, or any one or part thereof, is in such action held to constitute an infringement or misappropriation, or the use thereof is enjoined or restricted or if a proceeding appears to CONTRACTOR to be likely to be brought, CONTRACTOR will, at its own expense, either: (1) Procure for HHSC the right to continue using the Deliverables; or (2) Modify or replace the Deliverables to comply with the specifications and to not violate any intellectual property rights.

If neither of the alternatives set forth in (1) or (2) above are available to the CONTRACTOR on commercially reasonable terms, CONTRACTOR may require that

HHSC return the allegedly infringing Deliverable(s) in which case CONTRACTOR will refund all amounts paid for all such Deliverables.

The obligations of CONTRACTOR under this Section shall not apply in the event that HHSC, its employees or agents used, modified or combined the applicable Deliverable in a manner that caused the alleged infringement.

Section 13.03 ***Property Damage***

(a) CONTRACTOR will protect HHSC's real and personal property from damage arising from CONTRACTOR's, its agent's, Employees' and Subcontractors' performance of the Agreement, and CONTRACTOR will be responsible for any loss, destruction, or damage to HHSC's property that results from or is caused by CONTRACTOR's, its agents', Employees' or Subcontractors' negligent or wrongful acts or omissions. Upon the loss of, destruction of, or damage to any property of HHSC, CONTRACTOR will notify the HHSC Project Manager thereof and, subject to direction from the Project Manager or her or his designee, will take all reasonable steps to protect that property from further damage.

(b) CONTRACTOR agrees to observe and require its Employees and agents to observe safety measures and proper operating procedures at HHSC sites at all times.

Section 13.04 ***Risk of Loss***

During the period Deliverables are in transit and in possession of CONTRACTOR, its carriers or HHSC prior to being accepted by HHSC, CONTRACTOR will bear the risk of loss or damage thereto, unless such loss or damage is caused by the negligence or intentional misconduct of HHSC. After HHSC accepts a Deliverable, the risk of loss or damage to the Deliverable will be borne by HHSC, except loss or damage attributable to the negligence or intentional misconduct of CONTRACTOR's agents, Employees or Subcontractors.

Section 13.05 ***Limitation of Liability***

(a) *Direct Damages And Liability Cap*

EACH PARTY'S SOLE LIABILITY (WHETHER IN CONTRACT, TORT, NEGLIGENCE, OR BY STATUTE OR OTHERWISE) FOR ANY CLAIM IN ANY MANNER RELATED TO THIS AGREEMENT, SHALL BE THE PAYMENT OF DIRECT DAMAGES AND SUCH DAMAGES SHALL IN NO EVENT IN THE AGGREGATE EXCEED THE AMOUNT EQUAL TO ALL FEES PAID BY HHSC TO CONTRACTOR IN THE PRIOR TWELVE (12) CALENDAR MONTHS UNDER THIS AGREEMENT ("LIABILITY CAP").

(b) *No Liability for Consequential, Indirect, Special or Punitive Damages*

NOT INCLUDING LIQUIDATED DAMAGES SPECIFIED IN THIS AGREEMENT, NEITHER PARTY SHALL BE LIABLE TO THE OTHER FOR ANY CONSEQUENTIAL, INDIRECT, SPECIAL OR PUNITIVE DAMAGES, REGARDLESS OF WHETHER SUCH DAMAGES WERE FORESEEABLE.

(c) *CONTRACTOR Liability for Overpayments*

Notwithstanding the foregoing, CONTRACTOR shall be liable for any portion, inclusive of the State and Federal share, of overpayments attributable to failures by CONTRACTOR to

meet its obligations under this Agreement where CONTRACTOR has direct responsibility for the determination and processing of payments. The Parties explicitly agree that such amounts are deemed direct damages and that liability for such overpayments may exceed the Liability Cap up to an aggregate liability equal to the total contract value of this Agreement. CONTRACTOR's liability is contingent on HHSC diligently exercising its rights and best efforts to mitigate such overpayments. In the event of overpayments that are not attributable to provider fraud, HHSC shall first seek recovery from the applicable provider, but is not required to take legal action against such provider if HHSC reasonably determines that such actions would be contrary to the best interests of the State or the program. Prior to any recovery of any overpayments attributable to fraud, HHSC shall have the duty to pursue such overpayments from the provider, with CONTRACTOR acting as a payor of last resort and having no obligation until HHSC has exhausted such other remedies. Any amounts recovered by HHSC for overpayment shall reduce CONTRACTOR's liability under this Section. CONTRACTOR shall assist HHSC in the pursuit of any overpayments. Nothing in this Section shall preclude the ability of HHSC to pursue CONTRACTOR in the event of CONTRACTOR fraud.

Section 13.06 ***Duty To Mitigate***

Each Party has a duty to mitigate the damages that would otherwise be recoverable from the other Party pursuant to this Agreement by taking such actions as may be required under Texas law to reduce or limit the amount of such damages.

Article 14. Miscellaneous Provisions

Section 14.01 ***Prohibition Against Performance Outside the United States***

Unless otherwise expressly agreed by HHSC in writing and in advance, all work performed under this Agreement must be performed exclusively within the United States. All information obtained by CONTRACTOR or a Subcontractor under this Agreement must be maintained within the United States. In no event shall CONTRACTOR send any HHSC information or confidential data, or allow access to, outside of the United States. Notwithstanding the foregoing, HHSC acknowledges that CONTRACTOR is a global company and that its internal business processes related to this Agreement and associated costs may be incurred outside the United States. CONTRACTOR acknowledges that that no direct services for HHSC will be performed outside the United States nor may any direct costs for CONTRACTOR's internal business incurred outside of the United States be specifically allocated to HHSC.

(a) *Meaning of "within the United States" and "outside the United States."*

(1) As used in this Section 14.01 the term "within the United States" means any location inside the territorial boundaries comprising the republic of the United States of America, including of any of the 48 coterminous states in North America, the states of Alaska and Hawaii, and the District of Columbia.

(2) Conversely, the phrase "outside the United States" means any location that is not within the territorial boundaries comprising the republic of the United

States of America, including of any of the 48 coterminous states in North America, the states of Alaska and Hawaii, and the District of Columbia.

(b) *Maintenance of Confidential Information*

(1) CONTRACTOR and all Subcontractors, vendors, agents, and service providers of or for CONTRACTOR must not allow any Confidential Information that CONTRACTOR receives from or on behalf of HHSC to leave the United States by any means (physical or electronic) at any time, for any period of time, for any reason.

(2) CONTRACTOR and all Subcontractors, vendors, agents, and service providers of or for CONTRACTOR must not permit any person to have remote access to HHSC information, systems, or Deliverables from a location outside the United States.

(c) *Remedy*

(1) CONTRACTOR's violation of this Section 14.01 will constitute a material breach of this Agreement. CONTRACTOR will be liable to HHSC for all actual damages.

(2) For breach of the requirements under this Section 14.01 that are not cured within thirty (30) calendar days, HHSC may terminate this Agreement with Notice to CONTRACTOR at least 1 calendar day before the effective date of such termination.

Section 14.02 ***Ownership and Licenses***

The Parties agree that any Deliverable, including any software, developed by CONTRACTOR, and paid for by HHSC, in connection with the Agreement (the "Custom Software"), will be the exclusive property of HHSC.

HHSC will own all right, title, and interest in and to its Confidential Information and the Deliverables provided by CONTRACTOR, including without limitation the specifications, the work plan, and the Custom Software, except that the Deliverables will not include the third party software or CONTRACTOR proprietary software and the associated documentation for purposes of this Section. CONTRACTOR will take all actions necessary and transfer ownership of the Deliverables to HHSC, including any Custom Software and associated documentation on Acceptance or as otherwise provided in the Agreement.

CONTRACTOR will furnish Custom Software and documentation, upon request of HHSC, in accordance with applicable state law. All Deliverables, in whole and in part, will be deemed works made for hire of HHSC for all purposes of copyright law, and copyright will belong solely to HHSC. To the extent that any Deliverable under this Section does not qualify as a work for hire under applicable law, and to the extent that the Deliverable includes materials subject to copyright, patent, trade secret, or other proprietary right protection, CONTRACTOR assigns all right, title, and interest in and to Deliverables, including all copyrights, inventions, patents, trade secrets, and other proprietary rights in the Deliverables (including any proprietary right renewals) to HHSC.

Concurrent with the conveyance of ownership rights in all Deliverables from CONTRACTOR to HHSC, HHSC grants to CONTRACTOR a worldwide, non-exclusive, royalty-free, perpetual license to use, modify, and distribute such Deliverables, subject to applicable restrictions on any Confidential Information contained therein, for its internal business purposes and for use with other clients. Subject to payment, CONTRACTOR grants to HHSC, a worldwide, non-exclusive, royalty-free, perpetual license to use, modify, and distribute CONTRACTOR's proprietary software, subject to applicable restrictions on any Confidential Information contained therein, for its governmental purposes.

CONTRACTOR will, at the expense of HHSC, assist HHSC or its designees to obtain copyrights, trademarks, or patents for all such Deliverables in the United States and any other countries. CONTRACTOR agrees to execute all papers and to give all facts known to it necessary to secure United States or foreign country copyrights and patents, and to transfer or cause to transfer to HHSC all the right, title, and interest in and to such Deliverables. CONTRACTOR also agrees not to assert any moral rights under applicable copyright law with regard to such Deliverables.

HHSC will have ownership and unlimited rights to use, disclose, duplicate, or publish all information and data developed for HHSC by CONTRACTOR under or resulting from the Agreement. Such data will include all results, technical information, and materials developed for HHSC from CONTRACTOR in the performance of the Services hereunder, including but not limited to all reports, surveys, plans, charts, recordings (video or sound), pictures, drawings, analyses, source and object code, graphic representations, computer programs and printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the Services performed as a result of the Agreement. CONTRACTOR will reproduce and include HHSC's copyright and other proprietary notices and product identifications provided by CONTRACTOR on such copies, in whole or in part, or on any form of the Deliverables.

For all equipment or third party products that CONTRACTOR procures on behalf of HHSC, HHSC shall take title or license, as applicable, upon purchase of such items. In each case, subject to the terms of any applicable license, HHSC grants CONTRACTOR the right to use or license, such items solely for the purposes of delivering the Services herein.

Prior to procuring any new third party software product that may be included as part of a software Deliverable to HHSC, CONTRACTOR will provide to HHSC copies of the license agreement from the licensor of the third party software to allow HHSC to pre-approve the license agreement.

In accordance with 45 C.F.R. Part 95.617, all appropriate state and federal agencies will have a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, translate, or otherwise use, and to authorize others to use all materials, the Custom Software and modifications thereof, and associated documentation designed, developed, or installed with federal financial participation under the Agreement, including but not limited to those materials covered by copyright, all Software source and object code, instructions, files, and Documentation composing the System. The Parties acknowledge that, pursuant to such regulations, this provision does not apply to proprietary and custom off the shelf software.

Without limiting any obligations of confidentiality, each party shall retain all rights in, and will be free to, use its general knowledge, skills and experience, and any ideas, concepts, know-how, and techniques that are acquired or used in the course of this Agreement.

Section 14.03 ***Cooperation and Consent***

Each Party will cooperate with the other Party in good faith in the performance of its respective activities contemplated by this Agreement so that the purposes of this Agreement may be accomplished in a proper, timely and efficient manner.

Section 14.04 ***No Third Party Beneficiaries***

No provision of this Agreement expressly confers third-party beneficiary status on a person or entity. Nothing contained in this Agreement is intended or will be construed to confer upon any person or entity other than the Parties hereto any rights, benefits or remedies of any kind or character whatsoever, and no person or entity will be deemed a third-party beneficiary under or by reason of this Agreement.

Section 14.05 ***Neutral Construction***

The Parties have negotiated this Agreement and all of the terms and conditions contained in this Agreement at "arms" length, and each Party has had the opportunity to be represented by counsel during such negotiations. No term, condition, or provision contained in this Agreement will be construed against any Party or in favor of any Party:

(a) because such Party or such Party's counsel drafted, revised, commented upon, or did not comment upon, such term, condition, or provision; or

(b) because of any presumption as to any inequality of bargaining power between or among the Parties.

Section 14.06 ***Further Assurances***

HHSC and the CONTRACTOR covenant and agree that, subsequent to the execution and delivery of this Agreement and without any additional consideration, HHSC and the CONTRACTOR will execute and deliver any further legal instruments and perform any acts that are or may become reasonably necessary to effectuate the purposes of this Agreement.

Section 14.07 ***Entire Agreement***

This Agreement constitutes the entire agreement between the Parties with respect to the subject matter hereof and supersedes all prior and contemporaneous agreements and understandings, whether written or oral, between the Parties with respect to the subject matter hereof.

IN WITNESS HEREOF, HHSC and the CONTRACTOR have each caused this Agreement to be signed and delivered by its duly authorized representative.

Health and Human Services Commission	Accenture State Healthcare Services LLC
By:	By:
Charles Smith Executive Commissioner	Jonathan Andrews Chief Executive Officer
5-5-2017 Date	April 28, 2017 Date

EXHIBIT A

EXHIBIT B

EXHIBIT B
Attachment 1
Actuarial Support (ASC)

ASC - 0003
Communications
Respond to HHSC requests for information concerning actuarial data within the specified timeframe.

ASC - 0006
Data and Document Retention
Retain the most recent eighty-four (84) months of LTC claims history and supporting data, including online access to the most recent sixty (60) months of this information, with the remaining twenty-four (24) months of data capable of being loaded in a manner that supports claims reporting activities.

ASC - 0001
General
Provide the State with detailed claims monitoring data and assist with the interpretation of that data so that the State may define medical cost levels for the future.

ASC - 0002
General
Provide the State with accurate and timely charge, expenditure, recipient eligibility, and utilization data as required to support State budget forecasts, tracking, and modeling, including but not limited to:

a) Participating and non-participating eligible recipient counts and trends by program and category of eligibility;

b) Utilization pattern by program, recipient medical coverage groups, provider type, and summary and detailed category of service; and

c) Charges, expenditures, and trends by program with a summary, and detailed category of service lag factors between date of service and date of payment to determine billing and cash flow trends.

ASC - 0007
Reporting
Generate State identified expenditure and utilization data/reports on a schedule specified by the State. These include but are not limited to:

a) Expenditures by geographic area (e.g., statewide, county, service delivery area), recipient eligibility category, category of service, service type, units of service, number of claims, and programmatic group;

b) Number of eligible recipients, unduplicated eligible recipients, participating paid recipients, and unduplicated participating paid recipients by eligibility category, category of service, service type, and programmatic group;

c) Waiver and special program participation and expenditure data, including services, payments, billed amounts, number of eligible recipients, unduplicated paid (participating) recipient counts, total cost of care by date of service and date of payment;

d) Federally required waiver reports, by waiver and special program;

e) Present services provided under each waiver program in such a manner as to distinguish the services from information on the same services provided to non-waiver participants;

f) Provide electronic ST750 and ST650 files with county level (including unknown county 255) traditional fee-for-service and managed care incurred data on a fiscal quarter basis. Files should include two (2) complete fiscal years of history and current year data (deliver these files no later than the 3rd Friday after the end of each State fiscal quarter); and

g) Provide traditional Medicaid claims data broken out by State defined risk groups, including, but not limited to breakdowns by age; and

h) Provide additional detailed breakdowns of claims data on a monthly basis as defined by the State.

ASC - 0008
Reporting
Submit all actuarial reports for all programs as requested by the State with content and in a media and format approved by the State.

ASC - 0009
Reporting
Provide monthly encounter data to State-designated recipients in electronic format with content approved by the State.

EXHIBIT B
Attachment 2
Appeals and Complaints Resolution (ACR)

ACR - 0016
Administrative Appeals
Return original administrative appeal documents to the State within State directed guidelines and timelines.

ACR - 0017
Administrative Appeals
Image all provider administrative appeals and attachments.

ACR - 0018
Administrative Appeals
Maintain the automated administrative appeals tracking and retrieval system for State access.

ACR - 0020
Administrative Appeals
Process administrative appeals according to processes and procedures approved by the State.

ACR - 0021
Administrative Appeals
Make provider administrative appeals case files available to the State upon request.

ACR - 0022
Administrative Appeals
Compile a comprehensive case file of all materials and supporting documentation relevant to provider administrative appeals or requests for an adjustment of a claim, including the final determination of resolution.

ACR - 0023
Administrative Appeals
Notify providers of any administrative appeals claim adjustment requests with content and in a media and format and within established timelines approved by the State.

ACR - 0024
Administrative Appeals
Complete the research associated with the State's processing of provider appeals or adjustment requests and submit recommendation(s) to the State by the agreed upon processes and procedures and due date.

EXHIBIT B
Attachment 2
Appeals and Complaints Resolution (ACR)

ACR - 0027
Administrative Appeals
Respond to all complaints and inquiries submitted by the State (known as CATs) via portal application used by CONTRACTOR and State by the due date designated based on the category of the inquiry or complaint or as requested by the State.

ACR - 0028
Administrative Appeals
Maintain an online portal or secure electronic method and fax number to be used exclusively for the purpose of receiving client and provider complaints.

ACR - 0002
Client and Provider Complaints
Manage provider contact and correspondence records so that complete information for each provider is easily retrievable by State and State-approved business partners.

ACR - 0008
Client and Provider Complaints
Document client and provider appeals and complaints resolution accurately, clearly and in detail for all requests, regardless of source.

ACR - 0010
Client and Provider Complaints
Respond to, but not necessarily resolve, 100% of complaints and inquiries no later than five (5) business days from receipt of the request or as directed by the State.

ACR - 0012
Client and Provider Complaints
Maintain all supporting documentation of all client and provider appeals and/or complaint resolutions and make documentation available to the State as requested and within the timeframes specified by the State.

ACR - 0013
Client and Provider Complaints
Furnish providers with accurate information regarding provider appeals and complaint resolution process within timeframes, with content and in a media and format approved by the State.

EXHIBIT B
Attachment 2
Appeals and Complaints Resolution (ACR)

ACR - 0014
Client and Provider Complaints
Furnish clients with information regarding the client complaints resolution process and their right to a fair hearing. Such information must be accurate and written in the languages specified by the State within timeframes, with content and in a media and format approved by the State.

ACR - 0015
Client and Provider Complaints
Follow the established process approved by the State for documenting client and provider complaint resolution.

ACR - 0001
General
Maintain a Post Office Box for provider administrative appeals and provider and client complaints.

ACR - 0025
General
Educate providers, on an ongoing basis, about the appeal and resolution process, including the right to escalate to the State for resolution.

EXHIBIT B
Attachment 3
Call Centers (CCC)

CCC - 0056
Client Services
Provide a choice of at least three (3) providers when a fee-for-service client calls the client toll-free line requesting assistance with locating a doctor, dentist, or other provider where the data exists and is available. These providers must be accepting new patients as noted in the online provider lookup within a 30 mile radius of client location for primary care providers and a 75 mile radius of client location for specialty providers.

CCC - 0067
Client Services
Report for the Medicaid client general inquiry line the following call center metrics for the previous month by the twentieth (20th) business day of the month that includes: a) The monthly maximum average standard; b) The average speed to answer in queue; c) Blockage rate at all levels; d) The abandonment rate; and e) Percent calls answered by clearing the queue. Provide daily reports to the State until CONTRACTOR returns to compliance as defined by the State, if the monthly maximum average, 60 second average speed to answer, 2% blockage rate, or abandonment rate standards are not met for three (3) consecutive months. CONTRACTOR must provide a State-approved plan for correcting the problems resulting from the non-compliance in a media, format, and timeframe as approved by the State.

CCC - 0069
Client Services
Provide the agency name and telephone number to callers requesting program information from the following agencies. Callers will not be transferred to these agencies:

a) Texas 2-1-1 Information and Referral Network;

b) DADS Consumer Rights Hotline;

c) HHSC Office of Inspector General;

d) Social Security Administration Medicare; and

e) Transfer other calls to the appropriate help desks as approved by HHSC.

NOTE: The Medicaid Call Transfer line is a separate function and has a different call queue than the other helplines.

CCC - 0070
Client Services
Provide automated call transfers through menu selections when possible; otherwise, provide

instructions on who to contact.

CCC - 0111
Client Services
Provide names of certified Healthy Texas Women Program (HTW) providers to clients within the clients' service area and advise the clients to call back if they are unsuccessful in obtaining a HTW provider from the three (3) referrals.

CCC - 0151
Client Services
Maintain a 120-second monthly average speed to answer (ASA) per line as measured by the time in queue before being answered by an agent, for the Third Party Liability (TPL) lines.

CCC - 0157
Client Services
Maintain a zero percent call deflection rate for client call lines. Call deflection includes any call that is redirected, and then disconnected, due to high call volume.

CCC - 0003
General
Follow State-approved comprehensive training program for all toll-free line staff.

CCC - 0009
General
Maintain an automated system(s) for all toll-free lines that tracks and reports telephone calls and inquiries to ensure online retrieval of information regarding the call and the call recording (e.g., provider/client name and number, date, nature of the call, documented detailed response given, and call center agent ID). Maintain call data by program. Identify and propose call center industry standards and reporting that will be used. Final automated system(s) must be with standards and content, media, format, and data retrieval approved by the State.

CCC - 0012
General
Provide an automated system to answer all toll-free lines on weekends and holidays, with the capability to provide callers with operating hours. Set holiday and business hour messages as the primary message on the primary line. Automated access messages and other recorded business messages (as approved by the State programs) can be placed after that.

EXHIBIT B
Attachment 3
Call Centers (CCC)

CCC - 0016
General
Record and monitor calls from all toll-free telephone lines in accordance with the State-approved Quality Management Plan.

CCC - 0018
General
Provide State staff with automated access to recordings for six (6) years after the date of the telephone call unless otherwise specified by the State.

CCC - 0022
General
Obtain State approval before limiting the number of topics or inquiries that may be addressed during a call received from a provider or a client.

CCC - 0026
General
Provide the capability needed to support State users to monitor all toll-free line requirements.

CCC - 0035
General
Staff and operate toll-free phone lines from 7:00 a.m. to 7:00 p.m., CST, Monday through Friday (excluding State-approved holidays) unless otherwise approved by the State.

CCC - 0038
General
Provide to the State full access to all software used for recording calls and access shall be provided in the locations specified by the State.

CCC - 0039
General
Provide a copy of any recording to the State within five (5) business days of request.

CCC - 0051
General
Provide and operate toll-free telephone lines to respond to client and provider questions and resolve concerns.

EXHIBIT B
Attachment 3
Call Centers (CCC)

CCC - 0066
General
Obtain State approval at least thirty (30) calendar days prior to implementation or termination for any changes to the call tree, management of the toll-free lines or recorded messages, unless otherwise approved by the State.

CCC - 0112
General
Track and communicate via email to the State the number of Healthy Texas Women Program (HTW) calls received, abandoned rates, hold times, and average talk time on a weekly basis.

CCC - 0121
General
Maintain client and provider satisfaction within the call center operations using an approach to be mutually agreed by the State and CONTRACTOR.

CCC - 0152
General
Propose, implement, and maintain a call escalation process and procedure for referrals, issues and/or problem resolution.

CCC - 0153
General
Answer all calls according to the State-approved scripts and procedures. CONTRACTOR will not answer calls by clearing the queue. "Answering" only to ask callers to call back later or to tell callers that staff will contact them later is not allowed barring a Force Majeure event.

CCC - 0084
Provider Services
Provide interpreter services, including but not limited to a language line and Texas Relay, as necessary for the toll-free telephone lines. Services must be provided to the provider or client at no cost to callers.

CCC - 0086
Provider Services
Provide access to CONTRACTOR's Senior Medical Director and Dentist as needed to respond to provider escalated medical inquiries.

EXHIBIT B
Attachment 3
Call Centers (CCC)

CCC - 0087
Provider Services
Capture the types of provider questions that are received through the provider dedicated toll-free lines and make available to the State upon request in a content, format, and media approved by the State.

CCC - 0113
Provider Services
Communicate to Healthy Texas Women Program (HTW) providers, as per State-approved call center processes, the need to ensure that their HTW participation status and contact information is current and remain current and that they follow the program's rules.

CCC - 0115
Provider Services
Respond to all provider calls regarding the Texas Medicaid Attestation for Affordable Care Act (ACA) Primary Care Services Increases form and the supplemental payments.

CCC - 0150
Provider Services
For each provider line, call abandonment rate (in which the caller disconnects prior to the call being answered by a customer service representative) will not exceed 5%, measured monthly.

CCC - 0159
Provider Services
Maintain a call deflection rate of no more than 6% for prior authorization call lines, or an agreed upon threshold.

CCC - 0119
Third Party Liability
Provide and operate dedicated TPL (i.e., HIPP/IPPA, TPR, Tort) toll-free telephone lines to respond to client, provider, attorney, employer, and insurance carrier questions and inquiries and resolve concerns for the Medicaid and State and federal programs.

CCC - 0127
Third Party Liability
Staff and operate the Tort phone line from 8:00 a.m. to 5:00 p.m. CST, Monday through Friday (excluding State-approved holidays), unless otherwise approved by HHSC, and ensure callers

have the option to choose an extension, if known, to leave a message.

CCC - 0130
Third Party Liability
Track and report telephone inquiries on the HIPP and IPPA line in the HIPP Case Management system to ensure online retrieval of information regarding the call (e.g., client, employer, and insurance carrier name and number, date, nature of the call, documented detailed response given and call center agent ID).

CCC - 0131
Third Party Liability
Implement and maintain English and Spanish client TPL toll-free lines to assist clients. Information must be communicated in other languages upon request.

CCC - 0154
Third Party Liability
Staff and operate the toll-free TPL Pharmacy call center. Telephone lines must be available Monday through Friday from 8:30 a.m. to 5:30 p.m. CST. CONTRACTOR will provide a monthly toll-free line report, with content, format, and due date as specified by HHSC, to HHSC Vendor Drug Program.

CCC - 0155
Third Party Liability
Allow clients and pharmacy providers to contact the TPL call center to update and/or correct TPL coverage.

CCC - 0156
Third Party Liability
CONTRACTOR's TPL department will manage the TPL phone queue.

EXHIBIT B
Attachment 4
Children with Special Health Care Needs (CSHCN) Services Program

CSN - 0010
Enrollment
Enroll non-Medicaid provider types and CSHCN Services Program specific provider types in compliance with CSHCN Services Program rules, and approved processes and procedures.

CSN - 0003
General
Evaluate all projects under the Agreement for operational, system, procedural and policy changes for impact on the CSHCN Services Program. Report potential impacts and recommendations to the CSHCN Services Program during the project planning process. Coordinate implementation efforts with CSHCN Services Program and other associated programs.

CSN - 0006
General
Notify the CSHCN Services Program, no more than four (4) hours within Business Hours after discovery, when a CSHCN Services Program eligibility transmission did not complete CONTRACTOR's update process.

CSN - 0008
General
Submit daily updates of client third party resources information (e.g., primary insurance coverage) with content, and in a media, and format approved by the CSHCN Services Program.

CSN - 0023
General
Produce a CSHCN Services Program summary voucher and a detail voucher. Provide a detailed report on claim-specific and non-claim specific activity to CSHCN Services Program, using a format agreed to by the CONTRACTOR and CSHCN Services Program.

CSN - 0013
Processing
Initiate, or in response to a CSHCN Services Program request, develop, update, and implement edits and audits, procedure code and diagnosis groupings for the CSHCN Services Program. Obtain CSHCN Services Program approval for all edit and audit changes prior to implementation in accordance to State-approved change control processes.

EXHIBIT B
Attachment 4
Children with Special Health Care Needs (CSHCN) Services Program

CSN - 0015
Processing
Identify and re-process CSHCN Services Program claims for clients that have received retroactive Medicaid eligibility using State-approved processes and procedures.

CSN - 0020
Publications
Develop, translate, publish, and distribute a quarterly bilingual (English/Spanish) CSHCN Services Program family newsletter, with content, and in a media and format approved by CSHCN Services Program. The newsletter will focus on client benefits, client resources, and the CSHCN Services Program.

CSN - 0021
Publications
Develop, translate, publish, and distribute a bilingual (English/Spanish) CSHCN Services Program client handbook, within timeframes, with content, and in a media and format approved by CSHCN Services Program. CSHCN Services Program client handbooks must contain information regarding the program coverage benefits and limitations, contact information, client eligibility requirements, client rights and responsibilities, and all other information as directed by the program.

CSN - 0022
Publications
Distribute materials available through CSHCN Services Program as directed by CSHCN Services Program.

EXHIBIT B
Attachment 5
Claims & Encounters Processing (CPC)

CPC - 0049
Encounter Processing
Process encounters received from MCOs submitters via the X12 837 and National Council for Prescription Drug Programs (NCPDP) Post Adjudication (encounter) transactions. Edit inbound encounter data appropriately, as directed by the State.

CPC - 0050
Encounter Processing
Report to the State the encounter submittal rejection and warning error rates in a content, media, format, and frequency approved by the State.

CPC - 0052
Encounter Processing
Provide timely and consistent feedback to the State on error rates, issues, and problems with encounter data in a content, media, format, and frequency approved by the State.

CPC - 0053
Encounter Processing
Maintain encounter data using State-approved metrics from the encounter data warehouse.

CPC - 0131
Encounter Processing
Provide feedback to state contractors, including MCOs and MTOs, to improve error rates and data quality for encounters in a content, media, format, and frequency approved by the State.

CPC - 0005
Forms
Require providers to use the appropriate claim form and to submit a separate claim for services provided to each client; physicians, hospitals, and dentists to use standard CMS Forms (UB-04, CMS1500, and ADA). State specific claim forms include those used for Family Planning services.

CPC - 0006
Forms
Develop claim forms for State approval and include specific elements approved by the State.

CPC - 0007
Forms
Identify and update all ongoing claim forms based on national changes as they occur.

CPC - 0018
Processing
Follow established operational claim processes and procedures to ensure that all claims for services are adjudicated based on the Medical/Dental processes applicable on the date each service was actually rendered, unless explicitly directed otherwise by the State.

CPC - 0019
Processing
Process all claims using State-approved edits and audits.

CPC - 0022
Processing
Initiate adjustments on specified claims as directed by the State in accordance with State law, when a provider has been convicted of filing fraudulent claims.

CPC - 0023
Processing
Require the National Drug Code (NDC) on all outpatient provider administered drug claims for all applicable programs.

CPC - 0026
Processing
Maintain a claims transaction log reflecting disposition of all claims and associated control numbers and make available to the State upon request.

CPC - 0027
Processing
Process claims with a manually assigned Diagnosis Related Group (DRG) for Medicare Part A long term acute care facilities, rehabilitation hospitals and critical access hospitals.

CPC - 0033
Processing
Price claims for each program as directed by the State.

EXHIBIT B
Attachment 5
Claims & Encounters Processing (CPC)

CPC - 0035
Processing
Provide a method to process any specific claim for payment on an exception basis, as directed by the State, and maintain an audit trail.

CPC - 0039
Processing
Post all payment categories (i.e., TPL, deductibles, copayments, and co-insurance) to claims history.

CPC - 0047
Processing
Enter recoupment activity in the TMMIS, identifying the source and reason for each recoupment activity.

CPC - 0048
Processing
Receive, review, and process recoupment and repayment of claims identified by the State, with content, and in a media and format approved by the State.

CPC - 0051
Processing
Provide feedback to state contractors to improve error rates and data quality in a content, media, format, and frequency approved by the State.

CPC - 0058
Processing
Require Present On Admission (POA) indicators on inpatient claims (both paper and electronic) for all facility provider types.

CPC - 0077
Processing
Verify signatures are present on the high cost Durable Medical Equipment (DME) certification form for the client, DME provider, and QRP professional.

CPC - 0089
Processing

Accept 277CA responses and recompile and route responses back to submitters.

CPC - 0122
Processing
Modify the claims adjudication guidelines for system changes prior to implementation.

CPC - 0123
Processing
Maintain accurate adjudication guidelines in accordance with State-approved processes and procedures.

CPC - 0124
Processing
Accept incoming claim transactions from Managed Care Organizations (MCOs) providers for routing determinations to appropriate MCO and route to the MCO within twenty-four (24) hours of receipt. Provide a reference number back to provider and the MCO for those transferred claims.

CPC - 0125
Processing
Provide the capability to process managed care claims without applying current prior authorization rules, for new and/or existing procedure code groupings, as specified by the State.

CPC - 0126
Processing
Decrement authorized dollars and/or units from the PA file for each paid claim according to State-approved processes and procedures.

CPC - 0127
Processing
Adjudicate PHC claims and process sterilization consent forms in accordance with State policy.

CPC - 0128
Processing
Electronically submitted claims must either be assigned an Internal Control Number (ICN) or be rejected within twenty-four (24) hours of receipt.

EXHIBIT B
Attachment 5
Claims & Encounters Processing (CPC)

CPC - 0105
Reporting
Monitor and report the use of override codes by CONTRACTOR staff during the claims resolution process to identify potential abuse based on State-approved guidelines.

CPC - 0106
Reporting
Deliver an accurate, monthly STAT file as defined by the State no later than ten (10) calendar days following the last calendar day of the month.

CPC - 0109
Reporting
Capture, store, and maintain a rolling thirty-six (36) months of detailed claims information in the claims engine to allow for claims reprocessing.

CPC - 0110
Reporting
Archive claims information from the claims engine that is between thirty-six (36) and one-hundred twenty (120) months old.

CPC - 0111
Reporting
Provide the State and State-approved business partners with secure online access to the archived claims and encounter information from the TMMIS.

CPC - 0112
Reporting
Make the Preventable Adverse Event/Wrong Surgery National Coverage Determination monthly report available in the online ad hoc reporting tool by the twentieth (20th) business day of the month, with format approved by HHSC.

CPC - 0129
Reporting
Deliver a monthly report with information regarding LTC claims processing accuracy as approved by the State. This report will be provided monthly and include historical information with monthly claims processing totals and the sum total of all claims discovered to be processed incorrectly in a given month, irrespective of the date of discovery.

EXHIBIT B
Attachment 5
Claims & Encounters Processing (CPC)

CPC - 0002
State Access
Provide the State with access to electronic and/or original documents for all transactions processed in the media which it exists.

CPC - 0003
State Access
Generate the claims inventory and operations reports by program after each claims processing cycle and provide the State with electronic access.

CPC - 0004
State Access
Provide access to the Edifecs ICD-10 code management tool for up to ten (10) State and five (5) CONTRACTOR named users.

EXHIBIT B
Attachment 6
Client Eligibility File Maintenance (CEF)

CEF - 0002
General
Receive client eligibility files from the State, and load and process such files within the timeframes approved by the State. Coordinate the schedule for required daily eligibility file processing with all other scheduled system-related processes (e.g., monthly and daily eligible reconciliation file processing), to avoid conflicts and delays. Notify the State immediately if any load or process errors occur.

CEF - 0003
General
Maintain the TMMIS client eligibility data for all programs approved by HHSC.

CEF - 0004
General
Monitor and maintain all edits for the daily eligibility file process. Make recommendations to the State for changes, or to suppress edits that are not useful, and suggest new edits that could streamline the eligibility file process. Submit such recommendations to the State for approval within timeframes, with content and in a media and format approved by the State.

CEF - 0005
General
Perform a monthly data comparison between the TMMIS eligibility tables and the State Eligibility Systems eligibility files. Identify discrepancies, analyze results, and prepare a report containing the findings. Submit such report to the State for approval by the end of the business day following the comparison run, with content and in a media and format approved by the State. Implement approved updates within the timeframes designated by the State.

CEF - 0007
General
Work with appropriate State staff to resolve the eligibility data discrepancies identified as a result of the TMMIS eligibility file error reports.

CEF - 0008
General
Transmit the updated TMMIS TPL client and carrier interface files to the State eligibility system and State-approved business partners daily or as directed by the State.

EXHIBIT B
Attachment 6
Client Eligibility File Maintenance (CEF)

CEF - 0010
General
Maintain a process to ensure that interfaces include THSteps screening and treatment information from the TMMIS, including encounter data, as appropriate.

CEF - 0011
General
Produce and store all client eligibility reports to the State within timeframes, with content and in a format and media approved by the State.

CEF - 0012
General
Produce and deliver client error reports to the State daily, for each eligibility transaction (i.e., State Eligibility Systems interface and CSHCN Services Program file interface) in accordance with State-approved guidelines.

CEF - 0013
General
Maintain appropriate controls and audit trails to validate the most current client eligibility data is used during each claims processing cycle.

CEF - 0016
General
Identify the Medicaid Identification (ID) for laboratory transactions on a schedule directed by the State.

EXHIBIT B
Attachment 7
Client Services (CSC)

CSC - 0010
Correspondence
Maintain a Post Office Box to be used exclusively for the purpose of receiving client-initiated correspondence.

CSC - 0011
Correspondence
Develop and send written correspondence to clients using at the 4th to 6th grade reading comprehension level.

CSC - 0012
Correspondence
Respond to clients in the language in which the inquiry was received.

CSC - 0013
Correspondence
Maintain the ability to produce client address labels by program type to the State upon request.

CSC - 0014
Correspondence
Research and provide a complete and accurate response to clients' inquiries no later than thirty (30) calendar days from receipt of inquiry. In situations where billing history or medical records are required from an outside entity, the CONTRACTOR will complete research and respond to the client no later than sixty (60) calendar days from receipt of inquiry. Document the research and responses in the client correspondence records. Use State-approved letters for all responses.

CSC - 0015
Correspondence
Send a letter to the client when the correspondence has been forwarded to the appropriate State program when the correspondence is outside of the CONTRACTOR's purview. Send the letter to the client and forward a copy to the State on the same day.

CSC - 0017
Correspondence
For clients who inquire about their claim liability and who are enrolled in Managed Care Organizations (MCOs), forward inquiries and copies of any original documents received from

the client to the State no more than seven (7) calendar days from receipt.

CSC - 0018
Correspondence
Document, track, and make available for reporting, client-initiated correspondence within timelines in a content format and media specified by the State.

CSC - 0019
Materials
Make all client materials available in the languages of State-identified population groups.

CSC - 0020
Materials
Produce and distribute client materials as approved and directed by the State.

CSC - 0022
Materials
Edit, translate, print and distribute a fee-for-service client handbook for the Medicaid/CHIP programs and a comprehensive guide to Medicaid for community-based organization or other information as directed by the State, within State-approved timelines. All text for the handbook and community-based organization publication will be provided by the State per the established correspondence process. Prepare and obtain State approval of the layouts prior to printing.

CSC - 0023
Materials
Print fee-for-service client handbook once annually in sufficient numbers to allow for monthly distribution to all fee-for-services newly enrolled Medicaid clients.

EXHIBIT B
Attachment 8
Cost Containment (CCN)

CCN - 0001
General
Develop a business case for each proposed cost containment project at no additional cost to the State.

CCN - 0002
General
Business cases for cost containment projects shall include the metrics and methodologies to measure the proposed project value and benefits. Project value is defined as the projected annualized business case savings by state fiscal year. The projected annualized savings are computed using the net savings (benefit minus cost/investments) over a designated period of time.

CCN - 0003
General
Present cost containment business cases to the State for approval/rejection.

CCN - 0004
General
Develop a project plan for each State-approved cost containment project.

CCN - 0005
General
Track realization of the identified project value and benefits of each State-approved cost containment project.

CCN - 0006
General
Provide the State with the status of cost containment projects.

CCN - 0007
General
Develop and submit to the State a project closeout document for each State-approved cost containment project.

EXHIBIT B
Attachment 9
County Indigent Health Care Program (CIC)

CIC - 0002
General
Make payments for all CIHCP claims to the DSHS County Indigent Health Care Program in accordance with State-approved processes and procedures.

CIC - 0004
General
Assign a unique provider TPI number to every CIHCP provider and establish controls to ensure that CIHCP provider numbers are not used for processing non-CIHCP claims.

CIC - 0005
General
Maintain, update, and post the CIHCP services with allowable payment rates for Federally Qualified Health Centers, Rural Health Clinics, Outpatient Hospital and Inpatient Hospital percentages on the HHSC designated repository annually. CIHCP must approve of all content and rates before such information is posted on the HHSC designated repository.

CIC - 0008
General
Provide a contact person who is qualified, experienced and knowledgeable about CIHCP to assist with questions, operational problems/issues and any other issues that may arise.

EXHIBIT B
Attachment 10
Electronic Visit Verification (EVV)

EVV - 0001
Compliance
Provide Call Center support from 7 a.m. – 7 p.m. CST Monday through Friday for FFS providers seeking general information regarding EVV and/or to refer FFS providers to EVV vendors for EVV information, questions, and issues specifically related to the FFS provider's chosen EVV system through a 1-800 number which provides customer service tracking and reporting of such call data.

EVV - 0002
Compliance
Process monthly invoice received from EVV vendors within State specified timelines.

EVV - 0003
Compliance
Validate the EVV Daily Interface file against the current EVV data record. An automated EVV Daily Response File will be submitted to the EVV vendor within 24 hours of receipt.

EVV - 0005
Compliance
Obtain approval from HHSC prior to terminating any of CONTRACTOR's agreements with the EVV vendors in accordance with the termination provisions of such agreements.

EVV - 0006
Compliance
Provide routine, on-going training and education related to EVV data repository and EVV report repository as necessary for DADS, HHSC, and CONTRACTOR to occur no more than twice yearly.

EVV - 0007
Compliance
Maintain EVV provider list and corresponding EVV vendor selections.

EVV - 0008
Compliance
Participate in State enforcement proceedings as needed and support HHSC and/or DADS when compliance issues regarding FFS EVV result in contested actions or cases by providing

testimony on relevant aspects of the EVV system or EVV data.

EVV - 0009
Compliance
Perform FFS provider outreach and communication related to the EVV program.

EVV - 0010
Compliance
Maintain the EVV vendor selections made by Medicaid-enrolled providers providing services subject to EVV that are submitted to CONTRACTOR in accordance with State-approved EVV processes and procedures.

EVV - 0011
Compliance
Provide EVV vendor generated reports upon request from HHSC within specified timeframes.

EVV - 0012
Compliance
Maintain standard EVV visit maintenance reason codes used for submission and updates to EVV data sent.

EVV - 0004
Support
Process and deliver EVV finalized invoices to EVV vendors by the eleventh (11) day of the month.

EXHIBIT B
Attachment 11
Eligibility Verification System (EVS)

EVS - 0001
Data and System Requirements
Provide the automated capability to allow providers to access client eligibility data and other State-approved information or transactions at no cost to the providers.

EVS - 0002
Data and System Requirements
Provide the capability for providers to connect to the Interactive Voice Response (IVR) via a toll-free telephone line.

EVS - 0003
Data and System Requirements
Maintain the capacity to complete interactive inquiries (submit a request and return requested data) within twenty (20) seconds or less, 99% of the time. An interim response of "waiting" or "your request is being processed" does not meet the State's definition of complete.

EVS - 0005
Data and System Requirements
Provide the secure, online, real time capability to display and print inquiry results through the web portal.

EVS - 0006
Data and System Requirements
Update the automated eligibility inquiry system daily with data from the recipient tables including demographics, TPL, and information addressing eligibility benefits and limitations.

EVS - 0007
Data and System Requirements
Notify the designated State staff when the automated inquiry and transaction systems have been down for more than ten (10) consecutive minutes outside of the State-approved scheduled maintenance window. Initial notification must include a brief description of the incident and projected recovery time. Submit a follow-up notice to the State within ten (10) minutes of recovery, identifying total down time and resolution. Document and track all incidents and resolutions in an automated tracking system.

EVS - 0008
Data and System Requirements

Track all incidents of downtime for the automated inquiry and transaction systems with content and in a media and format approved by the State.

EVS - 0010
Data and System Requirements
Maintain the Medicaid Eligibility Health Information Services (MEHIS) Record Locator Service interface and limit claims data requests to a single Internal Control Number (ICN) based claim at a time.

EVS - 0011
Reporting
Provide the capability to produce a log and track all automated inquiries and transactions from providers and other State-approved business partners, with a minimum of thirty-six (36) months history.

EVS - 0012
Reporting
Document interactive inquiry response time and submit a monthly report to the State, with timeframes, in a content, media and format approved by the State.

EVS - 0013
Support
Provide software support, communication lines, and trouble-shooting assistance in support of automated inquiry functions, to providers, billing agents and other entities identified by the State, free of charge and as requested.

EVS - 0014
Support
Add State trading partners to receive TIERS formatted eligibility transaction responses per State approved processes and schedule.

EXHIBIT B
Attachment 12
Fair Hearings (FHC)

FHC - 0001
General
Follow established process for supporting the State's client fair hearings process for all applicable State programs, in accordance with State-approved guidelines.

FHC - 0003
General
Provide information presented to the client in an acceptable format for the hearing impaired, upon request.

FHC - 0004
General
Provide appropriate staff, as determined by the State, to support the State through written and oral testimony at client fair hearings, other legal proceedings, and in litigation. CONTRACTOR staff must attend client fair hearings and other legal proceedings, which are held by telephone, or face-to-face, as directed by the State. CONTRACTOR staff appearing at such hearings or proceedings must be knowledgeable about the pertinent policy related to the action taken by CONTRACTOR, and must be able to reference applicable State-approved processes, and procedures, as well as supporting documentation and evidence pertaining to the decision in dispute.

FHC - 0005
General
Receive requests for fair hearings from clients/authorized representatives via telephone, fax, mail, and email and process such fair hearing requests, including completion of all required forms and documents, within State specified timeframes, and in accordance with State-approved processes and procedures.

FHC - 0006
General
Provide case file materials to clients/authorized representatives within ten (10) business days of the State request or as directed by the State.

FHC - 0007
General
Prepare all documentary evidence (an evidence packet) necessary to support CONTRACTOR's action that resulted in the client fair hearing. Send the initial evidence packet to the fair hearings

officer and send a copy to the client/authorized representative no later than five (5) business days prior to the hearing.

FHC - 0009
General
Accept and review additional clinical information, received after notification letter for denial or reduction in benefits. This activity must be performed by the CONTRACTOR Medical Director. Such additional information may be collected after the notification letter for denial or reduction up until two (2) business days before the fair hearing.

FHC - 0010
General
Communicate with the client's physician, program staff, program nurses, home health agency staff, nursing facility physicians, nurses or physician assistants prior to the fair hearing, if additional information or clarification is needed.

FHC - 0011
General
Evaluate, and take appropriate steps to resolve where applicable, any issues/questions regarding the issue on appeal with appropriate State staff, as necessary, prior to attending the client fair hearing.

FHC - 0012
General
Develop for State approval and maintain a process to continue, without interruption, the client's benefits at current service levels, in accordance with State-approved processes, and procedures pending the outcome of the client's fair hearing.

FHC - 0014
General
Comply with the hearing officer's order and notify the hearing officer of such compliance, in a format and media approved by the State, within ten (10) business days of the date of the decision.

FHC - 0015
General
Provide qualified, experienced, and knowledgeable staff with case-specific expertise and knowledge to testify at fair hearings and supply, in addition to all supporting documentation, and

evidence for each case, as directed by the State.

FHC - 0017
General
Issue amended notification letter for approval or increase in benefits, based on the determination made when the additional information received during the fair hearing process has been reviewed, and send copies of the amended letter no later than five (5) business days of such determination to the client and the hearing officer.

FHC - 0018
General
Provide the State with a detailed and comprehensive file containing all relevant materials and supporting documentation describing the issue, resolution and final determination for all fair hearing appeals per established State-approved process.

EXHIBIT B
Attachment 13
Family Planning (FPC)

FPC - 0001
General
Respond to HHSC Family Planning (FPC) and/or Healthy Texas Women Program (HTW) inquiries within two (2) business days of the inquiry.

FPC - 0003
General
Create accounts receivables, reprocess claims, and notify providers about retroactive eligibility for HHSC Family Planning (FPC) and/or Healthy Texas Women Program (HTW) clients using State-approved processes and procedures.

FPC - 0004
General
Update HHSC Family Planning (FPC) and/or Healthy Texas Women Program (HTW) reimbursement rates, services, and provider and clinic listings within five (5) business days of change, or as requested by the State program.

FPC - 0005
General
Notify HHSC Family Planning (FPC) and/or Healthy Texas Women Program (HTW) providers and billing agencies of changes in rates and services, in compliance with State-approved procedures, and send within timelines, with content and in a media and format approved by the State.

FPC - 0010
General
Notify HHSC Family Planning (FPC) and/or Healthy Texas Women Program (HTW) within two (2) business days of termination or disenrollment when a HHSC Family Planning (FPC) and/or Healthy Texas Women Program (HTW) provider has been terminated or dis-enrolled from Medicaid.

FPC - 0011
General
In the event that a record is relevant to or the subject of litigation, an audit, dispute, administrative or other proceeding, the record retention period for Family Planning records begins on the date after the CONTRACTOR has been notified of the resolution of the

proceeding.

FPC - 0014
Processing
Record and maintain HHSC Family Planning (FPC) and/or Healthy Texas Women Program (HTW) claim level information on payments made to HHSC Family Planning (FPC) and/or Healthy Texas Women Program (HTW) providers, including the payment number and method (direct deposit or paper check), as received electronically from the state Fiscal Division.

FPC - 0015
Processing
Designate claims as "Funds Gone" when HHSC Family Planning (FPC) and/or Healthy Texas Women Program (HTW) funding is exhausted or no accounts receivables exist.

FPC - 0016
Processing
Automatically process and pay "Funds Gone" claims if additional funds or accounts receivable become available for the same year, or period as defined by the State, in which the services were provided.

FPC - 0018
Processing
Process HHSC Family Planning (FPC) and/or Healthy Texas Women Program (HTW) paper claims and paper encounters that are received in a format specified by the State. Make HHSC FPC- and HTW-approved paper claim and encounter forms available for download on the CONTRACTOR's web portal to authorized users.

FPC - 0025
Reporting
Create weekly payment records for electronic submission to the State Fiscal Division for HHSC Family Planning (FPC) and/or Healthy Texas Women Program (HTW) claims, and provide payment voucher and backup documentation to the State each week, in a format specified by the State.

FPC - 0026
Reporting
Report expenditures with accurate funding balances, by service month, for each HHSC Family Planning (FPC) and/or Healthy Texas Women Program (HTW) provider, on a weekly basis, or

as requested, and submit with content and in a media and format approved by the State.

FPC - 0027
Reporting
Allow authorized State staff to set up and maintain tools for HHSC Family Planning (FPC) and/or Healthy Texas Women Program (HTW) provider budget data and apply budget updates.

EXHIBIT B
Attachment 14
Reserved

[RESERVED]

EXHIBIT B
Attachment 15
Reserved

[RESERVED]

EXHIBIT B
Attachment 16
Financial Management (FIN)

FIN - 0115
General
Maintain, document, and submit operations cost data in accordance with the State Medicaid Manual, Section 11. As required by federal regulations or as may be required by State guidelines, documentation must differentiate between information technology and non-information technology, and will include the reimbursable federal matching rates for each type. Such cost allocation reports must be in a format and content approved by HHSC. The format of these reports must allow the State to comply with federal reporting requirements and to compare operations cost data to the Cost Proposals and Price Summary information.

FIN - 0005
General
Develop, submit for State approval, and execute quality assurance (QA) procedures to ensure that the financial management system disburses, tracks, and accounts for State program payments and recoveries accurately, within timeframes, with content, in a media and format approved by the State.

FIN - 0008
General
Deposit all checks within one (1) business day of receipt (except for Tort checks, which must be validated for legal reasons prior to deposit, in accordance with State-approved Tort processing rules).

FIN - 0009
General
Process stale-dated checks pursuant to the following guidelines:

a) Void all stale-dated checks that have not been cashed after one-hundred eighty (180) calendar days after the original issue date;

b) In the event that a provider has not cashed a check after one-hundred twenty (120) calendar days after the original issue date, send a letter notifying the provider that the check will be voided when it becomes one-hundred eighty (180) calendar days old;

c) Void the stale-dated check and apply it as a provider refund to an accounts receivable to prevent voiding the transaction and re-establishing an already satisfied receivable;

d) Use a payment status code to track stale-dated checks; and

e) Report stale-dated checks on the FINR274 report, with content, and in a media and format approved by the State.

FIN - 0010
General
Maintain the capability to apply partial vendor holds by dollar amount or percentage. Include partial vendor holds on the voucher at the time of the hold. Exclude partial vendor holds from the voucher when the hold is released.

FIN - 0011
General
Disposition refunds and systematically determine the fiscal year, risk group, and agency, using the most readily available information. For all non-claim specific refunds, use the disposition date to derive the fiscal year.

FIN - 0012
General
Refund and report TPL recoveries, excluding pharmacy and encounter recoveries, to the State weekly. Report to the State the total dollars transferred with content, in a media and format approved by the State.

FIN - 0013
General
Develop and maintain a secure system for storing checks, and monitor the disposition status of provider and third party liability recovery checks.

FIN - 0014
General
Issue provider payments in electronic funds transfer (EFT) or paper check format.

FIN - 0015
General
Produce and mail, or transmit electronically, all 1099 earnings reports, in accordance with federal and State law, no later than January 31st of each year as required by law, or as directed by the State.

EXHIBIT B
Attachment 16
Financial Management (FIN)

FIN - 0016
General
Research and respond to all inquiries concerning 1099 information, within the timeframes required by law, or as directed by the State.

FIN - 0017
General
Develop and maintain a State-approved contingency plan for creating payment vouchers for provider reimbursement, in the event that the voucher detail is not available on Monday morning. Use the previous week's vouchers or STAT expenditure report to determine appropriate payment amounts to the State's bank account.

FIN - 0018
General
Identify each claim with the account and revenue codes required for tracking to the State accounting system as requested by the State.

FIN - 0125
General
Process disposition of all checks (excluding TPL recovery checks and other State specified exceptions) within ten (10) business days of deposit. Provide a monthly report of exceptions items including: checks with dispositions in excess of 250 claims, checks without documentation required to post the check, checks waiting on financial cycle to change claim status and corrections as required. At least two (2) attempts must be made to contact providers regarding any missing documentation. Send monthly payout reports in timeframes, format, and media approved by the State.

FIN - 0126
General
Submit the weekly Children with Special Healthcare Needs (CSHCN) Detail Voucher and CSHCN Summary Voucher to the CSHCN Services Program via secure file transfer protocol (SFTP) prior to 10:00 a.m. CST Monday for expenditures processed for the week with content, in a media and format approved by the State.

FIN - 0134
General
Identify and track providers who are terminated, out-of-business, or bankrupt, and, track any

corresponding outstanding accounts receivable.

FIN - 0135
General
Follow established State-approved check-handling procedures for all TPL checks received.

FIN - 0136
General
Maintain a lock box to accept recovered funds specifically for encounters recoveries.

FIN - 0137
General
Refund pharmacy and encounters TPL recoveries to the State, on a monthly basis. Report to HHSC the total dollars transferred, within timeframes, with content and in a media and format approved by the State.

FIN - 0041
Recoupments and Adjustments
Impose payment holds and recoupments on providers based on State-approved procedures, unless otherwise directed by the State.

FIN - 0042
Recoupments and Adjustments
Apply provider holds and recoupments to all programs, except HHSC Family Planning (FP) and Healthy Texas Women Program (HTW) or when exception is directed by the State.

FIN - 0043
Recoupments and Adjustments
Set up accounts receivables by provider within each program.

FIN - 0044
Recoupments and Adjustments
Identify all National Provider Identifier (NPI)/Atypical Provider Identifier (API) or core Texas Provider Identifier (TPI) numbers, with all suffixes, and enforce the recoupment, hold, payment plan, or other HHSC recovery action, as requested by HHSC.

FIN - 0045
Recoupments and Adjustments
Develop, obtain approval, implement, follow, and update State-approved accounts receivable collection procedures, which must include State-approved collection performance standards, performance goals, and service levels.

FIN - 0046
Recoupments and Adjustments
Monitor and actively pursue accounts receivables, including manual intervention, in accordance with current State-approved processes and procedures.

FIN - 0048
Recoupments and Adjustments
Apply funds to open accounts receivable balances prior to issuing a payment to a provider, by matching open accounts receivables based on a provider's National Provider Identifier/Atypical Provider Identifier number, tax identification number, or same legal entity.

FIN - 0049
Recoupments and Adjustments
Process cash payments and payment offsets from a provider and apply each to a single accounts receivable.

FIN - 0050
Recoupments and Adjustments
Provide the sum total of the recoupments and a single unpaid balance, and make such information available on the online screens and reports.

FIN - 0052
Recoupments and Adjustments
Separate the accounts receivable reporting and tracking processes, which includes Accounts Receivable set-up, collections, and monitoring, both systematically and operationally from other miscellaneous financial tracking processes so that account balances are not co-mingled.

FIN - 0053
Recoupments and Adjustments
Follow established process to identify private provider claim-specific accounts receivable and report monthly by claim paid date. Identify and report monthly, public provider claim-specific

accounts receivable by the month of service (MOS) on the claim. Identify and report monthly, non-claim-specific accounts receivable by accounts receivable set-up date. Identify and report monthly, certified public providers separately from non-certified providers, so that the State can claim the proper State match for the certified funds.

FIN - 0054
Recoupments and Adjustments
Perform the State-approved process for identifying, sending proper notification, archiving, and collecting outstanding accounts receivable(s), including manual intervention.

FIN - 0055
Recoupments and Adjustments
Provide and manage communication with the provider in attempts to collect a debt.

FIN - 0056
Recoupments and Adjustments
Provide the ability to set up an accounts receivable and extract a percentage of a payment to a provider, by National Provider Identifier/Atypical Provider Identifier, tax identification number or same legal entity.

FIN - 0057
Recoupments and Adjustments
Track Accounts Receivables (AR) in the quarterly AR reporting per the requirements applicable to Program 300 HHSC Family Planning (FP) and/or Healthy Texas Women Program (HTW).

FIN - 0123
Recoupments and Adjustments
Collect funds due to the State from providers, either through cash payments or through offsets to provider payments.

FIN - 0124
Recoupments and Adjustments
Separate refunds due to the State from providers, by type, for payment errors, duplicate payments, overpayments, and excessive payments from interest refunds.

FIN - 0058
Reporting

Produce weekly provider payment hold reports after the weekly financial cycle, and submit to the State, with content, and in a media, and format approved by the State.

FIN - 0059
Reporting
Produce, at a frequency defined by the State, Remittance and Status reports electronically and simultaneously transmit or deliver the correct Remittance and Status with each payment to a provider. Produce and deliver hard copies of the Remittance and Status only as requested.

FIN - 0060
Reporting
Submit separate Risk Group Voucher delimited files for each applicable State agency, and provide to the State on a weekly cycle, by 10:00 a.m. CST, on a day of the week established by the State. Submit an interface file to HHSC that agrees with the delimited file. Submit vouchers to the State, with content, and in a media, and format approved by the State.

FIN - 0061
Reporting
Provide a monthly refund/recoupment Month Of Service supplemental report to each applicable State agency for the years the State received enhanced or American Recovery Reinvestment Act funding (e.g., FFY03, FFY04, FFY09 and FFY11) with content, and in a media, and format approved by the State. Report refunds/recoupments by Month Of Service so that HHSC can report the refunds/recoupments at the appropriate federal rate.

FIN - 0062
Reporting
Produce an annual report documenting any accounts receivable balances owed to the State, and submit to the State within thirty (30) calendar days after the end of each State Fiscal Year, with content as specified by the State, in a media and format approved by State.

FIN - 0063
Reporting
Report accounts receivable category criteria using the same attributes as claims expense vouchering criteria, and submit to the State within timeframes, with content, and in a media, and format approved by the State.

FIN - 0064
Reporting
Provide the Office of Inspector General (OIG) with a report identifying those already-paid provider claims that are the subject of an intended adjustment by CONTRACTOR, but that are also within the scope of an OIG investigation of the provider. The report must contain all of the data elements identified by the State, and must be provided in the media, format, manner, and frequency directed by the State.

FIN - 0065
Reporting
Refrain from adjusting those already-paid provider claims that are the subject of an intended adjustment by CONTRACTOR, but that are also within the scope of an OIG investigation of the provider, unless the State first provides written approval of the intended adjustment.

FIN - 0066
Reporting
Provide HHSC with a regular report identifying those already-paid provider claims that have been adjusted, with the advance written approval of HHSC. This regular post-adjustment report must also contain all of the data elements identified by HHSC, and must be provided in the media, format, manner, and frequency directed by HHSC.

FIN - 0069
Reporting
Provide the following in a monthly report that details any cost settlements that have taken place:

a) Contract year-to-date by hospital;

b) Accounting period;

c) Interim settlement;

d) Final settlement;

e) Pending settlements; and

f) Any other data as required by the State.

FIN - 0073
Reporting
Report to the State, by program, any amounts collected on accounts receivables older than 365

calendar days.

FIN - 0076
Reporting
Report all refunds and recoupments on a monthly basis. Report claim-specific refunds/recoupments to the applicable Federal Fiscal Year based on the month of service for public providers. Report claim-specific refunds/recoupments for private providers to the current Federal Fiscal Year. Report non-claim specific refunds/recoupments to the current Federal Fiscal Year. Compare and confirm the sum of the refunds/recoupments on the weekly Risk Group Vouchers to the monthly refund/recoupment reports.

FIN - 0078
Reporting
Report payment holds on the vouchers at the time the hold occurs and exclude from the vouchers at the time the hold is dispositioned.

FIN - 0079
Reporting
Report weekly in a format, content, and media approved by the State any Accounts Receivable that have been downward adjusted, or the provider has been flagged as terminated, out-of-business, or bankrupt.

FIN - 0080
Reporting
Maintain system flexibility to track different types of Accounts Receivables and the related Accounts Receivable activity.

FIN - 0082
Reporting
Do not spend a disproportionate amount of time collecting Accounts Receivables (ARs) with CONTRACTOR liability, as compared to non-CONTRACTOR liability ARs. The effort for both types shall be proportionate to the maximum extent practicable.

FIN - 0083
Reporting
Provide aging Accounts Receivable report to the State in support of collection of account

receivables with content as specified by the State, in a media and format approved by the State.

FIN - 0085
Reporting
Participate in a Post Project Implementation Review meeting upon request by the State by the date specified following the implementation of each project or Change Order Request (COR). The CONTRACTOR must include all the appropriate, knowledgeable staff applicable to participate in post project implementation review meetings for each respective COR.

FIN - 0086
Reporting
Prepare and submit a Post Project Implementation Actual Report five (5) business days prior to the Post Project Implementation Review meeting. The report should include the estimated hours as compared to the actual hours and any other supporting documentation in a media, content and format requested by the State.

FIN - 0120
Reporting
Provide an electronic file of all 1099 B-notices sent to providers and insurance carriers by tax year in tax ID order within thirty (30) calendar days of the date of the notices.

FIN - 0121
Reporting
Provide a cumulative annual report of the status of all backup withholding from providers including Tax ID by January 31st with content, and media and format approved by the State.

FIN - 0122
Reporting
Provide a file of all 1099 corrections sent to providers, insurance carriers and the IRS for each tax year on a monthly basis.

FIN - 0127
Reporting
Report weekly, in a format, with content and in a media approved by the State, Accounts Receivables that have aged over 365 calendar days from the discovery date with the exception of CMS-directed and State-directed exclusions.

EXHIBIT B
Attachment 16
Financial Management (FIN)

FIN - 0128
Reporting
Create a monthly Category of Service Voucher for each State agency to support the State's federal reporting requirements. Exclusions and inclusions on the weekly voucher and the monthly expenditure reports need to agree. The total of the weekly vouchers should equal the monthly expenditure totals.

FIN - 0129
Reporting
Submit to HHSC on the 30th day of the 3rd month of each federal quarter, an interim report of public provider claims with the date of service that must be reported and claimed by HHSC on the CMS64 within the federal eight (8) quarter deadline rule.

FIN - 0130
Reporting
Provide to HHSC a monthly report, based on the financial cycle, of the claims processed as Federal Category of Service Line 49 Other Care Services categorized by State Category of Service with content, in a media, and format approved by the State.

FIN - 0131
Reporting
Provide to HHSC a monthly report, based on the financial cycle, of the claims processed as Federal Category of Service Line 12 Home Health for only those claims identified as Durable Medical Expenditures categorized by Equipment & Supplies with content, in a media, and format approved by the State.

FIN - 0138
Reporting
Generate Medlog reports and interfaces based upon hospital fiscal year with fee-for-service claim and managed care encounter data to support the cost settlement process.

FIN - 0098
System
Separate administrative operational transactions from any transactions related to the cost containment projects.

EXHIBIT B
Attachment 16
Financial Management (FIN)

FIN - 0105
System
Receive, log, track, and enter Surveillance and Utilization Review (SUR) recovery checks into the TMMIS, in accordance with State-approved timelines, processes, procedures and QA processes.

FIN - 0109
System
Provide and maintain system functionality which is flexible enough to accommodate the need for sudden implementation and separate reporting for disasters and special requests from the State.

FIN - 0110
System
Maintain a process to capture (load or data enter) and track all adjustment transactions in the TMMIS, with complete audit trails.

FIN - 0111
System
Link the financial subsystem to the claims processing subsystem and the provider subsystem, so that accounts can electronically link specific claims to a provider.

FIN - 0112
System
Update claims history and online financial files with the check number, date of payment, and amount paid, within one (1) business day after the claims payment cycle.

FIN - 0113
System
Maintain the State-approved functionality to appropriately bucket/assign claims for STAT reporting.

FIN - 0114
System
Establish and maintain a process to coordinate STAT bucketing/assignments with State staff.

EXHIBIT B
Attachment 17
Reserved

[RESERVED]

EXHIBIT B
Attachment 18
Front End Services (FES)

FES - 0006
General
Image each page of every document that is received by the mailroom at a resolution of no less than three-hundred (300) dpi black and white.

FES - 0007
General
Assign a unique control number to every digital document per State approved procedures and within the specified timeframes.

FES - 0008
General
Key paper claims within the timeframes.

FES - 0009
General
Maintain original hard copy claims, make them retrievable, and ensure hard copy claims are not destroyed without prior State approval.

FES - 0010
General
Retain and archive digital provider enrollment agreements, addendums and supporting documents according to the HHS Agency Records Management Policy and Retention Schedule(s).

FES - 0011
General
Retain claims in active dispute and all supporting documentation until the dispute is resolved and State has approved either storage or destruction.

FES - 0012
General
Retain ten (10) days of completed work on hand (DWOH) before documents are sent for long-term storage off-site.

EXHIBIT B
Attachment 18
Front End Services (FES)

FES - 0013
General
Provide and maintain a document tracking system to track incoming paper and electronic documents from receipt through archive. State must have at least read only access.

FES - 0014
General
Provide and maintain a document tracking system to include a manifest of boxes sent to offsite storage. State must have at least read only access.

FES - 0015
General
Organize, track, and maintain existing and newly archived records in a manner that supports retrieval of requested records within State directed timelines. State must have at least read only access.

FES - 0016
General
Maintain, retain, archive data and documentation and restore as directed by the document retention requirements, including any applicable litigation hold. Data and documents will be available electronically to ensure that CONTRACTOR and State staff continually have access to the information necessary to perform the daily operational tasks and activities.

FES - 0017
General
Date and time stamp and data enter Medically Needy Program mail into the Medically Needy Program electronic inquiry system within twenty-four (24) hours of receipt.

FES - 0018
General
Date and time stamp Long Term Care (LTC) mail on the date and time it is received. Date and timestamp LTC mail received on an official holiday or weekend with the date and time of the following business day.

FES - 0019
General
Perform the following services for High Cost Durable Medical Equipment (DME) Categories

during receipt of the paper documents (mail room): a) Verify forms are completed correctly by providers. If any forms are missing either the provider or client signatures, CONTRACTOR (mailroom staff) will return copies of the forms to the providers; b) Image and index the forms and enter the images in the storage and retrieval database; c) Transmit the forms data to the workflow queue for processing.

FES - 0020
General
Perform State approved quality analysis (QA) procedures of FES functional requirements.

FES - 0021
General
Receive requests for fair hearings from clients/authorized representatives by fax or mail within State specified timeframes and in accordance with State-approved policies and procedures.

FES - 0022
General
Maintain and support an online, automated process that allows viewing by the State and CONTRACTOR of a replica of correspondence received and scanned. The process will support the ability to retrieve, display, and print provider correspondence, including correspondence to and from field based CONTRACTOR Provider Relations Specialists.

FES - 0023
General
Image provider administrative appeals and attachments at a resolution of no less than three-hundred (300) dpi black and white. Return the original documents to the State in accordance with HHS Agency Records Management Policy and Retention Schedule(s).

FES - 0024
General
Follow established State approved check-handling procedures for checks received (*e.g.*, Third Party Liability (TPL) carrier checks, ACA Provider Reenrollment checks).

FES - 0025
General
Image at a resolution of no less than three-hundred (300) dpi black and white and store electronic payment, denial, and correspondence documentation, in accordance with the HHS Agency

Records Management Policy and Retention Schedule(s).

FES - 0026
General
Retain cancelled checks in accordance with the HHS Agency Records Management Policy and Retention Schedule(s).

FES - 0027
General
Deposit checks into the appropriate bank account (e.g., Core Title XIX or Children with Special Health Care Needs (CSHCN) Services Program) within specified timeframes.

FES - 0028
General
Process (receive, prep, scan, and index) paper prior authorization (PA) requests within specified timeframes.

FES - 0029
General
Process (receive, prep, scan, and data enter) provider correspondence no later than twenty-four (24) hours from date and time of receipt by the CONTRACTOR mailroom.

FES - 0030
General
Process (receive, prep, scan, and data enter) all other correspondence excluding paper claims, prior authorization, provider correspondence, return to provider correspondence, and bad address returns within three (3) business days of receipt by the CONTRACTOR mailroom.

FES - 0031
General
Process return to provider (RTP) correspondence and bad address returns within five (5) business days of receipt by FES.

FES - 0032
General
Mark as received for the next business day, the daily volume of fax/email received after 5:00

p.m. CST on any given business day.

FES - 0033
General
Pick up mail from both post office locations twice a day, Monday through Friday on State defined business days. The last mail pick up will be completed no later than 11:00 a.m. CST.

FES - 0034
General
Route paper claims, prior authorization requests, and provider enrollment applications received through front end services operations with 98% accuracy in accordance with State approved criteria.

EXHIBIT B
Attachment 19
Fund Management (FMG)

FMG - 0001
Banking
Maintain and update banking and finance operating procedures which are subject to review and approval by the State.

FMG - 0003
Banking
Provide the State by the 15th business day of the following month with an electronic copy of each bank account monthly statements accompanied by schedules showing daily cash balances including, but not limited to, any information related to maintaining sufficient cash management techniques to produce reports that meet the requirement of the CMIA.

FMG - 0005
Banking
Provide the reconciliations for each bank account within forty-five (45) calendar days of each applicable month end.

FMG - 0011
Banking
Refund the State for any payment errors, including duplicate payments, overpayments, and excessive payments that are the result of errors by the CONTRACTOR. If payment is not recovered from the provider within State specified timeframes or includes amounts that are not eligible for Federal Financial Participation (FFP) reclaiming, the CONTRACTOR will pay the State the amounts due in accordance with the Agreement.

FMG - 0039
Banking
Establish and maintain separate bank accounts, as needed, in a bank located within the State of Texas. The accounts are identified as, but not limited to: (1) Core Title XIX Medical Benefits Account, (2) Core Title XIX Refund Account, (3) CSHCN Medical Benefits Account, and HIPP/IPPA Accounts. Any funds transferred into these accounts will become the liability of the CONTRACTOR upon deposit.

FMG - 0038
General

EXHIBIT B
Attachment 19
Fund Management (FMG)

Identify refunds of all claims with payment errors by applicable service year and service month.

FMG - 0017
Processing
Maintain a table of receivable reason codes that designate adjustments to accounts receivable (e.g., adjustments due to split/merge, cost report received, accounts receivable keying error, State request, etc.).

FMG - 0018
Processing
Report claim specific receivables at the claim detail level to ensure claim details are tracked to the appropriate agency and apply recoupments down to the detail level in hierarchy order as defined by the State.

FMG - 0019
Processing
Calculate the 365 calendar days for accounts receivable from date of discovery not from date of service or paid date of claim. Allow the discovery date to be modified only for non-claim specific accounts receivable and establish completed audit trail(s) for all modifications. Only allow the discovery date to be changed prior to reporting on the weekly accounts receivable overage balance report. Once reported, disable the ability to modify the discovery date.

FMG - 0023
Processing
Do not make Medicaid payments to private entities after eight (8) federal quarters from the payment date on the original claim. Do not make crossover payments to private entities after eight (8) federal quarters from the crossover date on the claims. Unless otherwise directed by the State, Medicaid payments older than this will be denied with a provider message on the Remittance and Status notice and indication of amount that would have been paid.

FMG - 0024
Processing
Prepare, at a frequency defined by the State, the Remittance and Status (R&S) notice documenting all denied, paid, and pending claims. The Remittance and Status notice will include the following information sections: a) Message (program and benefit plan designated); b) Paid and denied claims; c) Accounts receivable; d) Adjustments;

e) Financial items; f) Pending claims; g) Payment summary; and h) Explanation of EOB/EOPS codes appearing on the Remittance and Status notice.

FMG - 0025
Processing
Retain images of all cancelled checks for all claim payments.

FMG - 0026
Processing
Comply with the legal requirements of any liens and levies received from the IRS, the Texas Attorney General's Office, the Texas Comptroller of Public Accounts, and any other legal notice of liens against providers, which includes withholding of child support obligation.

FMG - 0027
Processing
Update the provider file within twenty-four (24) hours of any liens and levies received from the IRS, the Texas Attorney General's Office, the Texas Comptroller of Public Accounts, and any other legal notice of liens against providers, which includes withholding of child support obligations.

FMG - 0028
Processing
Recoup erroneous Electronic Health Record (EHR) incentive payments made to providers through State-approved contract payment recovery processes. Independent reimbursement to HHSC for unsuccessful recoupments will not apply to incentive payments.

FMG - 0029
Reporting
Deliver monthly recoupment activity data to HHSC in electronic format within ten (10) calendar days after the monthly cycle completion.

FMG - 0031
Reporting
Monitor and review claim payments and report, with content, and in a media, and format approved by the State. Initiate corrective action within ten (10) business days to correct payment and voucher reporting on any mismatches in public/certified indicators, missing effective

public/non-public indicators, and report section/pages not found on crosswalk.

FMG - 0034
Vouchers
Exclude refund payouts from the Weekly Risk Group voucher. This includes interest payments, pharmacy payouts and refunds from other insurance companies that could not be dispositioned.

EXHIBIT B
Attachment 20
General (GOC)

GOC - 0205
Administration
Submit all required plans and reports to the State and receive approval from the State prior to implementation of the plans and reports (*i.e.*, Annual Business Plan, Disaster Recovery Plan, Enterprise Reports). Approval includes the content, formant and timeframes specified by the State.

GOC - 0214
Quality Management
Perform quality assurance tasks and reviews according to State-approved Quality Management Plan.

GOC - 0016
Data and Document Retention
Develop and submit a Data Security Plan to the State for approval, within six (6) months after the Contract Start Date. The Data Security Plan must comply with current State-approved processes and procedures and include encryption of Protected Health Information (PHI) and a plan for notifying the State of security violations.

GOC - 0017
Data and Document Retention
Maintain and update existing State-approved procedures to ensure that data maintained on the Texas Medicaid Management Information System (TMMIS), or in other system/manual files to support operations, and email systems, are properly and routinely archived and protected from loss, unauthorized access, or destruction.

GOC - 0018
Data and Document Retention
Ensure that archived data is available (in a media and format specified by the State) within no more than three (3) business days of the request or as agreed upon by the State.

GOC - 0022
Data and Document Retention
Retain and maintain all email for the term of the Agreement. This includes all emails turned over by previous contractors and all emails of subcontractors.

EXHIBIT B
Attachment 20
General (GOC)

GOC - 0024
Data and Document Retention
Store archived email with metadata in a searchable and retrievable format according to standard industry format or practice.

GOC - 0025
Data and Document Retention
Cooperate with all State and federal entities performing inspections, audits, and reviews and provide assistance as requested, including access to or copies of necessary records and information.

GOC - 0026
Data and Document Retention
Maintain processes and procedures to ensure that all State-approved deliverables and documents received are scanned in a manner that preserves image quality, and are properly stored in electronic format and retained. Documents must be available for online viewing by State staff and State-approved trading partners, as appropriate. Maintain, archive and protect documents from loss, unauthorized access, or destruction. Adhere to data archive process and retention schedules as directed by the State.

GOC - 0028
Data and Document Retention
Comply with the HHS Agency Records Management Policy and Retention Schedule(s), except where a different retention period is specified.

GOC - 0029
Data and Document Retention
Retain at a minimum the most recent one-hundred twenty (120) months of claims and encounter history, including online access to the most recent sixty (60) months of claims and encounter information, with the remaining sixty (60) months capable of being loaded in a manner that supports claims processing activities unless otherwise specified by the State.

GOC - 0030
Data and Document Retention
Indefinitely retain all records for clients under the age of twenty-one (21) for all Medicaid programs in accordance with the Frew v. Smith litigation hold.

EXHIBIT B
Attachment 20
General (GOC)

GOC - 0209
Data and Document Retention
Transfer a rolling one-hundred twenty (120) months of claims and encounters history to the data warehouse. Maintain an online archive history file with a claims history audit trail.

GOC - 0238
Data and Document Retention
Retain at a minimum the most recent one-hundred-eighty (180) months of claims and encounter history, including online access to the most recent sixty (60) months of the claims history, with the capability of loading the remaining one-hundred-twenty (120) months, in a manner that supports claims reporting activities. In addition, CONTRACTOR needs to retain additional months of claims history capable of being loaded in a manner that supports claims reporting.

GOC - 0044
Documentation
Maintain and distribute all State-approved TMMIS documentation used to support the State's business functions within timelines, with content, and in a media and format approved by the State. TMMIS documentation and updates must be clear, concise, accurate, and easily referenced. Use industry standards during the development and maintenance of all State-approved documentation. All new TMMIS documentation or modifications to existing documentation must be reviewed and approved by the State prior to distribution.

GOC - 0045
Documentation
Conduct a QA review to confirm all document change requests are complete prior to distribution to the State. Maintain and update all documentation in accordance with State-approved criteria and industry standards.

GOC - 0047
Documentation
Maintain controls, as part of the QA process, to ensure that all components of correspondence, documentation, and deliverables received are tracked and retrievable.

GOC - 0048
Documentation
Ensure that modifications to original documentation are incorporated using a State-approved version control process.

EXHIBIT B
Attachment 20
General (GOC)

GOC - 0049
Documentation
Create and maintain all documentation in a media, content, and format approved by the State. All documentation developed by the CONTRACTOR on behalf of the State becomes the property of the State.

GOC - 0050
Documentation
Maintain a tracking system for documentation that will record all activities associated with maintenance for all manuals produced for internal and external stakeholders.

GOC - 0051
Documentation
Coordinate, schedule, facilitate, prepare agendas and produce meeting minutes and distribute within State designated timeframes, not to exceed five (5) business days of a meeting. Retain and upload all minutes and agendas in the documentation tracking system, according to State-approved timelines and record retention guidelines. The minutes must be in a media, content and format as defined by the State and at a minimum, include the list of attendees, decision summaries and statement of action items, when applicable. Minutes must represent an accurate summary of the meeting discussion. Meetings that require meeting minutes, include but are not limited to: Recurring State and CONTRACTOR meetings, Governance meetings, Change Order Request (COR) meetings, Service Request Meetings, and any official meetings in which decisions are made or considered that may alter requirements or have a potential financial impact to the contract. Meeting minutes are for the purpose of documenting meeting discussion only and will not serve as the vehicle to alter contract language. Meeting minutes and agendas are required for any meeting upon request and at the direction of the State.

GOC - 0053
Fraud, Waste and Abuse
Provide a full fee-for-service and encounter claims extract to the Medicaid Fraud and Abuse Detection System (MFADS) in accordance with HHSC approved requirements.

GOC - 0054
Fraud, Waste and Abuse
Provide full Medicaid acute care fee-for-service/encounter provider file, reference file, and code table extracts to the Medicaid Fraud and Abuse Detection System (MFADS) in accordance with HHSC approved requirements.

GOC - 0055
Fraud, Waste and Abuse
Provide full Non-Emergency Medical Transportation (NEMT) claims, encounters, provider file, reference file, and code table extracts to the Medicaid Fraud and Abuse Detection System (MFADS) in accordance with HHSC approved requirements.

GOC - 0056
Fraud, Waste and Abuse
Provide full Medicaid Long Term Care claims, encounters, provider file, reference file, and code table extracts to the Medicaid Fraud and Abuse Detection System (MFADS) in accordance with HHSC approved requirements.

GOC - 0057
Fraud, Waste and Abuse
Provide full Medicaid Vendor Drug Program claims, encounters, provider file, reference file, and code table extracts to the Medicaid Fraud and Abuse Detection System (MFADS) in accordance with HHSC approved requirements.

GOC - 0058
Fraud, Waste and Abuse
Provide a full Medicaid client file extract for all Medicaid and State programs to the Medicaid Fraud and Abuse Detection System (MFADS) in accordance with HHSC approved requirements.

GOC - 0059
Fraud, Waste and Abuse
Provide a full extract of Minimum Data Set assessment data to the Medicaid Fraud and Abuse Detection System (MFADS) in accordance with HHSC approved requirements.

GOC - 0060
Fraud, Waste and Abuse
Provide Medicaid Fraud and Abuse Detection System (MFADS) an electronic copy of all licensing board files received to meet other State-approved requirements within State-approved timeframes.

GOC - 0061
Fraud, Waste and Abuse
Provide a full prior authorization file extract for all Medicaid programs to the Medicaid Fraud

and Abuse Detection System (MFADS) in accordance with HHSC approved requirements.

GOC - 0208
Fraud, Waste and Abuse
Confirm client receipt of High Cost Durable Medical Equipment according to State-approved processes and procedures.

GOC - 0222
Fraud, Waste and Abuse
Refer all known instances of possible or suspected waste, abuse, and fraud directly to the State for investigation and determination, and notify program staff in a timely manner about notification to the State of possible or suspected waste, abuse, and fraud.

GOC - 0223
Fraud, Waste and Abuse
Maintain procedures for making referrals for suspected waste, abuse, and fraud directly to the State, and submit to the State for approval prior to implementation. Procedures must include:

a) Educating staff at all levels and in all areas of claims administration, on ways to recognize possible waste, abuse and fraud;

b) Providing the ability for staff, at all levels, to freely and directly refer all instances of possible or suspected waste, abuse, and fraud to the State without interference, or required approval from the CONTRACTOR's management; and

c) Educating staff on how to make a direct referral to the State.

GOC - 0224
Fraud, Waste and Abuse
Post conspicuous notice of the HHSC hotline and other HHSC mediums available to employees for reporting fraud, waste or abuse in HHSC Programs in the CONTRACTOR's common work and break areas (e.g., conference rooms, reception area, restrooms, elevators, break rooms, hallways, etc.).

GOC - 0002
General
Provide a live person(s) (i.e., Receptionist or Operator) at the Austin facility during business hours (8:00 a.m. to 5:00 p.m. CST) to respond to phone calls from visitors or customers under

the Agreement.

GOC - 0003
General
Provide a live person(s) during business hours to issue badges to visitors at the Austin facilities.

GOC - 0015
General
Provide support for modifications to established reports. Specific operational and contract management activities reports will not be considered as ad hoc/special reports and may include the following:

a) Capacity planning reports;

b) Project staffing and status reports;

c) Systems availability and downtime reports;

d) Telecommunication statistics;

e) Security access reports;

f) Response time reports measuring performance at peak and off-peak hours;

g) Reports that provide the ability to measure compliance with the required deliverables defined in the Agreement; and

h) Other reports specifically mentioned in the Agreement (i.e., monthly progress reports and Blue Ribbon data file reports).

GOC - 0207
General
Submit updated call center metrics within thirty (30) calendar days of identification of changes, if call center metrics are updated based on actual performance, technology changes, or any other circumstances.

GOC - 0210
General
Provide an updated staffing list quarterly by name, functional area including email addresses and office phone numbers.

GOC - 0211
General
Provide and maintain qualified, knowledgeable, and professional staff that will have interaction with the public, the State, and State-approved business partners.

GOC - 0219
General
Update the electronic copy of the medical/dental policy manual located in the eOPM on the same day the State-approved changes to the medical/dental policies are operationally implemented or as directed by the State. Provide official notification to the State when policies are added to or updated in the eOPM.

GOC - 0220
General
Provide at a minimum the following Texas licensed clinical practitioners:

a) Dentist – Must be licensed as a dentist by the Texas State Board of Dental Examiners; this practitioner may be a part time staff position or a contractor;

b) A sufficient number of qualified, experienced, and knowledgeable medical/dental clinical staff licensed in Texas, including physicians, registered nurses, therapists, dental hygienists, orthodontists and psychiatrists; and

c) Physician and dentist backups.

GOC - 0221
General
Develop new ad hoc reports within timeframes, with content, and in a media and format approved by the State.

GOC - 0225
General
Produce, maintain and deliver Enterprise Reports in a format, content and media, and within timeframes approved by the State.

GOC - 0226
General
Produce, maintain and deliver Operations Reports in a format, content and media, and within

timeframes approved by the State.

GOC - 0227
General
Produce, maintain and deliver Key Measures Reports in a format, content and media, and within timeframes approved by the State.

GOC - 0228
General
Notify HHSC's Civil Rights Office of any civil rights complaints received relating to its performance under the Agreement. This notice must be delivered no more than ten (10) calendar days after receipt of a complaint. Notice provided pursuant to this section must be directed to:

HHSC Civil Rights Office

701 W. 51st Street, Mail Code W206

Austin, Texas 78751

Phone Toll Free: (888) 388-6332

Phone: (512) 438-4313

TTY Toll Free: (877) 432-7232

Fax: (512) 438-5885.

GOC - 0231
General
Produce, maintain, and deliver a Staff Training Plan in a format, content and media, and within timeframes approved by the State. The Staff Training Plan should provide a plan for both CONTRACTOR and State staff training include topics, but not limited to: TMMIS automated systems, functionality, procedures, processes, interfaces, etc.

GOC - 0232
General
Maintain sufficient secure, climate-controlled, storage for all record types stored as defined by the State.

GOC - 0233
General

EXHIBIT B
Attachment 20
General (GOC)

Maintain access to all facilities and operations for all State-authorized staff during the hours of 7 a.m. to 6 p.m. CST Monday through Friday and other hours as specified by HHSC in advance (e.g., providing 24-7 hour access during Texas legislative sessions).

GOC - 0241
General
Respond timely to information request associated with the AICPA – Service Organization Control 2 (SOC 2), Type II audit at the end of each Operational Contract Year to provide assurance related to data security, availability, processing integrity, confidentiality, and privacy, and provide the results of each audit to HHSC as soon as is practicable upon completion.

GOC - 0242
Quality Management
Submit Deliverable Expectation Documents for any deliverable requested by the State on an agreed timeline.

GOC - 0062
Key Personnel
Provide a list of designated Key Personnel and, except as approved by the State, ensure that such personnel are dedicated to the performance of the Agreement. Key Personnel must be full-time personnel that are knowledgeable, experienced, and qualified to perform the responsibilities of the position under the Agreement. Any redirection of Key Personnel to perform functions other than the responsibilities of the positions identified for the performance of the Agreement, either temporarily or permanently, will require prior State approval. HHSC reserves the right to approve the hiring or require the removal of any Key Personnel, Employee, or Subcontractor employee.

GOC - 0063
Key Personnel
Provide the State with written notification ten (10) business days prior to making any planned changes in Key Personnel (other than for death) and obtain the State's written approval before making any permanent or temporary changes in Key Personnel.

GOC - 0064
Key Personnel
Provide an organizational chart with Key Personnel identified and a staffing plan to the State for approval within five (5) business days of the Operational Start Date. Provide an updated organizational chart and staffing plan to the State on a quarterly basis and within ten (10)

business days when a key person is replaced.

GOC - 0067
Key Personnel
Key Personnel positions must not remain vacant for longer than thirty (30) calendar days without prior written approval by the State.

GOC - 0069
Location
Maintain contract based facilities for Operations in Austin, Texas. The Operations facility must provide the infrastructure necessary to support all required State staff functions and provide rent free office space amenities for State designated employees, equal in quality and size to the amenities afforded the CONTRACTOR's Austin based employees. The office space must meet the Americans with Disabilities Act accessibility standards and be approved by the State. During the Operations Phase, CONTRACTOR may propose other locations that could provide greater efficiency and cost effectiveness, provided that utilization of the other location shall be approved by the State in its sole discretion. The CONTRACTOR will perform the following activities at the Austin facility:

1. Provider relations and enrollment;

2. Claims receipt, prescreening, and transfer of claims and other documents to electronic media;

3. Contract administration and key personnel responsibilities;

4. Data entry, including paper copy and EMC transactions;

5. Exception claims processing (suspense resolution);

6. Claims appeal support;

7. Claims administrative reviews;

8. Business financial operations (e.g., handling manual checks, accounts receivable, and cash activity);

10. Client Services Unit;

11. Maintenance and modification activities;

12. Prior Authorization and medical policy and review services support;

13. Third party liability support; and

14. Administrative reviews and appeal support for assigned business functions.

The CONTRACTOR must maintain a minimum number of on-site systems support personnel to ensure effective communication and management of systems projects. The CONTRACTOR may perform internal administrative functions related to CONTRACTOR's business, including computer processing support, outside of Texas but within the continental United States.

GOC - 0070
Location
Develop and submit for State approval the Physical Security Plan, within six (6) months after the Contract Start Date. The Physical Security Plan is to be for the primary CONTRACTOR facility and each off-site facility, including storage facilities and security guards, with media, format and content approved by the State.

GOC - 0071
Location
Review and revise the Physical Security Plan and submit updates to the State for approval annually. The Physical Security Plan must be approved by the State and contain the security procedures to be implemented at each facility, including access limitations. the State reserves the right to perform physical security checks of the CONTRACTOR's facilities at its discretion.

GOC - 0073
Operations
Notify and obtain approval from the State prior to scheduling non-emergency system downtime or maintenance (for TMMIS) during hours of operation as documented in the State-approved System Availability and Incident Notification Process.

GOC - 0075
Operations
Execute and perform mass adjustment processing by the requested due date, which includes finalizing within ten (10) business days of receipt of State approval, or on a schedule agreed to by the State. Mass adjustment processing includes suspended claims.

GOC - 0077
Operations
Provide documentation and prepare detailed reports to assist the State with the preparation of the State's Medicaid Cost Allocation Plan as required by the State. Responsibilities include tracking personnel hours by position and allocating labor rates to various Federal Financial Participation

(FFP) rates, based on position descriptions, job responsibilities and processes or systems impacted.

GOC - 0078
Operations
Participate with the State and State-approved trading partners in the development and implementation of corrective action plans and/or assessments as required by court order.

GOC - 0087
Operations
Support file based interchange to receive laboratory data from DSHS.

GOC - 0103
Operations
Provide all information related to Open Records requests in a timeframe, content and media determined by the State.

GOC - 0105
Processes and Procedures
Develop, implement, and maintain written processes and procedures for all programs under the Contract. Develop documentation within timeframes, content, and in a media and format approved by the State. Use accurate, clear, and consistent language to describe CONTRACTOR functions.

GOC - 0106
Processes and Procedures
Submit a processes and procedures manual to the State with final versions of all updated processes and procedures for all TMMIS operations within agreed upon timeframes with the State.

GOC - 0107
Processes and Procedures
Maintain accurate and complete processes and procedures within the Electronic Operational Procedures Manual (eOPM). Publish processes and procedures within the eOPM within five (5) business days of State approval or as directed by the State. Notify the State when adding or updating processes and procedures in the eOPM.

EXHIBIT B
Attachment 20
General (GOC)

GOC - 0110
Processes and Procedures
Ensure all updates to the processes and procedures are dated, formatted and are clearly identified to the reader.

GOC - 0111
Processes and Procedures
Maintain online access to historical versions of the eOPM. All versions must be available for audit purposes.

GOC - 0112
Processes and Procedures
Maintain a cross-reference of each process and procedure with the corresponding State policy or requirement source, and make the information available to the State.

GOC - 0140
Processes and Procedures
Implement State-approved processes and procedures (P&P) upon project implementation or as directed by the State.

GOC - 0212
Processes and Procedures
Maintain an accurate and complete Tables Manual within the Electronic Operational Procedures Manual (eOPM). Publish updates to the Tables Manual upon system implementation. Notify the State when adding or updating the Tables Manual in the eOPM.

GOC - 0213
Processes and Procedures
Maintain accurate and complete content within the Electronic Operational Procedures Manual (eOPM). Publish and/or update contents within the eOPM as directed by the State. Notify the State when adding or updating content in the eOPM.

GOC - 0229
Processes and Procedures
Comply with Executive Order RP 80, issued December 3, 2014,

relating to use of the U.S. Department of Homeland Security's E-Verify

system.

GOC - 0126
Project Management
Use a State-approved Software Development Life Cycle (SDLC) management process to ensure a structured approach to information systems development and operation to include the following:

a) An accountable sponsor for each system project;

b) Appoint a single project manager for each system project;

c) A required comprehensive project management plan for each system project; and

d) Emphasize data management, accessibility, and security throughout the life cycle.

GOC - 0127
Project Management
Maintain State-approved project management tool(s) for the management of operations. The statuses included in the tool(s) must be limited to open, closed, and pending to ensure standardization and traceability of work products throughout the contract. Develop and use reason codes as rationale for any other activities/statuses related to specific business transactions within the operational area. Document notes within the tool using clear, specific and comprehensive language, including dates, action items, next steps, and decisions made with corresponding due dates. Obtain State approval for exceptions to these requirements before implementation.

GOC - 0130
Project Management
Provide a post implementation actual report within ninety (90) calendar days of deployment and implementation with information needed to complete Department of Information Resources (DIR) or other State reporting.

GOC - 0134
Quality Management
Develop and maintain a Quality Management Plan in a content, media, and format approved by the State. Submit the Quality Management Plan to the State for approval within timeframes agreed upon with the State. The Quality Management Plan scope must include all areas of the Contract and State-approved methodologies for measuring quality.

GOC - 0137
Quality Management
Review and update the Quality Management Plan annually and revise within thirty (30) calendar days of a State directed change in State and/or federal policy. Submit the revised Quality Management Plan to the State for approval prior to implementing.

GOC - 0138
Quality Management
Provide the State access to all data used in execution of the Quality Management Plan within five (5) business days of request.

GOC - 0145
Quality Management
Report any contract compliance deficiencies and operational issues to the State, that impact service delivery to clients, providers, and/or State-approved trading partners upon discovery.

GOC - 0146
Quality Management
Submit root cause analyses, Corrective Action Plans, and plans for resolving deficiencies and operational issues within seven (7) calendar days of request or as otherwise directed by the State.

GOC - 0147
Quality Management
Maintain TMMIS according to State-approved processes and procedures required to pass periodic reviews as may be conducted by CMS, State, federal, or independent auditors.

GOC - 0168
Quality Management
Meet with all operational areas of the Contract quarterly to discuss trends in Quality Management and Monitoring.

GOC - 0159
Reporting
Maintain current online listing and description of reports produced and distribution requirements with content and format approved by the State.

EXHIBIT B
Attachment 20
General (GOC)

GOC - 0160
Reporting
Maintain the report distribution list and schedule to reflect updated State decisions on format, media, and distribution, including distribution to other State-approved trading partners and State staff.

GOC - 0162
Reporting
Modify established reports to meet the changing business and information needs of the State utilizing the change control process as appropriate. Respond to requests for changes from the State or other State-approved trading partners.

GOC - 0163
Reporting
Produce, maintain and deliver accurate reports for all State-approved reports and other outputs within the timeframes specified by the State and according to the format, input parameters, content, frequency, media, distribution criteria, and number of copies required by the State.

GOC - 0167
Reporting
Meet with the State to discuss focus areas for the development of the Annual Business Plan.

GOC - 0171
Reporting
Provide comprehensive and accurate responses to all official correspondence, including proposed solutions to any deficiencies and/or discrepancies identified, within thirty (30) business days of receipt, or by the date specified on the correspondence.

GOC - 0215
Reporting
Develop an Annual Business Plan and submit the plan to the State on a date mutually agreed upon by the State prior to the beginning of each contract year, with content, and in a media and format approved by the State.

GOC - 0216
Reporting
Conduct a six-month evaluation report of the Annual Business Plan and submit within

timeframes specified by the State.

GOC - 0240
Quality Management
Submit work products and deliverables across all business functions with an acceptable level of quality per quality review/peer review checklists.

GOC - 0080
System Privacy and Security
Process new requests or updates to TMMIS user accounts within five (5) business days of request or on a scheduled agreed to by the State.

GOC - 0180
System Privacy and Security
Create and maintain unique role-based user IDs and passwords for secure authorized access to the TMMIS and maintain as part of the security profile. Password configuration must be compliant with all current State-approved processes and procedures.

GOC - 0181
System Privacy and Security
Protect all data and voice connectivity between TMMIS interfaces, transmission lines, communications bridges, and linkages from unauthorized access. Immediately report all privacy and/or security incidents upon discovery, including breaches to State designated personnel in accordance with Data Use Agreement (DUA) requirements. Submit a root cause analysis and CAP to the State within five (5) business days of the incident, and meet and confer with the State thereafter as requested. Submit a quarterly report summarizing privacy incidents to the State via MCATS with content, media, and format approved by the State.

GOC - 0182
System Privacy and Security
Establish, support and facilitate State-approved secure FTP process to exchange, (send and receive) all file extracts with the State and State-approved business partners within the State specified timeframe.

GOC - 0183
System Privacy and Security
Provide a secure outbound communication process to address emails transmitted to the provider

for Disproportionate Share Hospital (DSH) claim and encounter appeals and ensure all protocols apply to the handling of unsolicited Protected Health Information (PHI). Maintain the use of TxMedCentral secure FTP for the purpose of receiving provider appeals for DSH claims, encounters, and for sending appeal information back to providers.

GOC - 0184
System Privacy and Security
Comply with established State-approved processes for any CONTRACTOR in-home workers in order to ensure compliance with all security and privacy requirements, including the in-home worker guidelines and in-home worker agreement, which specifically address adherence to HIPAA and IT security guidelines. Staff will be required to sign the CONTRACTOR inventory agreement acknowledging the use of CONTRACTOR issued computers and mandatory return of issued computers to the CONTRACTOR in the event of termination of employment.

GOC - 0217
System Privacy and Security
Provide State-authorized users secure access to data and information within TMMIS as directed by the State.

GOC - 0234
System Privacy and Security
Establish, implement and maintain an ongoing Security Plan to address: systems of risk assessment and periodic assessments, risk management security measures, and information system activity risk reviews.

GOC - 0235
System Privacy and Security
Establish, implement and maintain an Incident Response Plan for mitigating, to the maximum extent, any harmful effects of an unauthorized use or disclosure of confidential Information or a breach, including without limitation, Protected Health Information (PHI). Such Incident Response Plan shall be consistent with the Data Use Agreement (DUA) incorporated into the contract.

GOC - 0236
System Privacy and Security
Ensure that all employees, subcontractors and workforce are adequately trained and educated, and attend an annual refresher or retraining on confidentiality, privacy, security and the importance of promptly reporting any Event or Breach as defined in the DUA and of the

consequences of failing to do so, including without limitation: employment disciplinary action, employer sanctions or enforcement actions for legal noncompliance, potential loss of HHSC's Federal Financial Participation, and risks to third-party agreements.

GOC - 0237
System Privacy and Security
Establish and maintain a hosted domain and create email addresses for use for all communications related to the Contract. The domain, name, registration, and all data will be the State's property and transferrable to the State at the conclusion of the contract.

GOC - 0185
Training, Education and Materials
Conduct annual assessments of training needs for State staff and State-approved trading partners related to the use of TMMIS automated systems, functionality, procedures, processes, interfaces, data structures, quality management activities, reports, and other training needs to understand the business processes required for all operations.

GOC - 0186
Training, Education and Materials
Provide ongoing training to State staff and State-approved trading partners on the use of TMMIS based on the annual assessment and/or as requested by the State.

GOC - 0187
Training, Education and Materials
Develop for State approval a comprehensive Computer Based Training (CBT) training course for new employees, and refresher training, and make available to State staff. Content of the training material is subject to State approval.

EXHIBIT B
Attachment 21
Health Insurance Premium Payments (HIPP) and Insurance Premium Payment Assistance (IPPA)

HIP - 0005
Reporting
Submit all State-approved HIPP/IPPA reports to the State within timeframes, with content and in a media and format approved by the State.

HIP - 0006
Reporting
Submit an annual report that includes a statistical analysis of the estimated cost savings associated with the HIPP program with content and in a media and format approved by the State.

HIP - 0009
Support
Identify eligible HIPP/IPPA cases by performing a cost-effective analysis. If payment of the policy premium is determined to be cost-effective, open the HIPP/IPPA case.

HIP - 0011
Support
Perform outreach and identify potential HIPP clients as directed by the State.

HIP - 0014
Support
Enter HIPP/IPPA insurance data into the TMMIS TPR subsystem.

HIP - 0015
Support
Maintain the HIPP/IPPA case management system.

HIP - 0016
Support
Verify and maintain all necessary client-specific data, including pay stub data, Medicaid and CSHCN Services Program eligibility data, and employer data to determine a client's eligibility for HIPP and IPPA premium reimbursement, as directed by the State.

EXHIBIT B
Attachment 21
Health Insurance Premium Payments (HIPP) and Insurance Premium Payment Assistance (IPPA)

HIP - 0019
Support
The CONTRACTOR is responsible for the administrative and infrastructure tasks and activities required in performing daily operations; and monitoring and tracking performance toward meeting those requirements, in support of the HIPP and IPPA programs.

HIP - 0020
Support
Update, maintain and store all data needed for program administration and quality monitoring activities.

HIP - 0022
Support
Perform monthly reconciliation of HIPP/IPPA payment data from the HIPP/IPPA case management system to the TMMIS. Reconciliation should include outstanding payments, voids, stop payments, reissues, stale dated checks, and cleared payments.

HIP - 0028
Support
Track cost-effective cases monthly to confirm continued Medicaid Program and/or CSHCN Services Program eligibility prior to issuing premium reimbursement. Review active cases annually to confirm continued cost-effectiveness as approved by the State.

HIP - 0029
Support
Develop for State approval HIPP information, and educational materials and distribute to clients, caseworkers, employers and State staff as requested. Obtain State approval for all HIPP information, and educational materials prior to publication.

HIP - 0030
Support
Conduct State-approved HIPP training, as requested. Present HIPP information to employer's onsite, as requested.

HIP - 0031
Support

EXHIBIT B
Attachment 21
Health Insurance Premium Payments (HIPP) and Insurance Premium Payment Assistance (IPPA)

Provide accurate, timely, customer-oriented, and comprehensive materials for CONTRACTOR's HIPP and IPPA training, publications and correspondence activities in support of the HIPP goals and objectives.

EXHIBIT B
Attachment 22
Long Term Care (LTC)

LTC - 0043
Communications
Send DADS approved correspondence to providers and individuals in accordance with the timeframes in the DADS program rules. Client correspondence must notify the individual of the right to appeal all denials for medical necessity.

LTC - 0054
Data and Document Retention
Provide online access to at least the most recent thirty-six (36) months of Long Term Care, non-claims data (i.e., service authorizations, client eligibility, provider eligibility and contracts).

LTC - 0060
Data and Document Retention
Retain all forms completed electronically on the LTC Online Portal for a rolling sixty (60) months.

LTC - 0061
Data and Document Retention
Maintain Minimum Data Set assessments pulled from the State database for the nursing facility program for a rolling sixty (60) months.

LTC - 0243
Data and Document Retention
Data and documents must be available online and electronically to ensure that CONTRACTOR and State staff continually have the necessary access to information to perform the operational tasks and activities.

LTC - 0062
Forms
Manage and maintain the LTC Online Portal in compliance with State-approved processes and procedures.

LTC - 0063
Forms
Process State-approved Long Term Care (LTC) forms to the LTC Online Portal within three (3)

business days of submission as directed by the State.

LTC - 0067
Forms
Confirm the receipt of State-approved Long-term Care (LTC) forms submitted to the LTC Online Portal on the same day of submission.

LTC - 0072
Forms
Deliver to the State each business day, electronic files containing all forms that have been processed in the LTC Online Portal that day. Resend lost files to the State within three (3) business days of discovery.

LTC - 0073
Forms
Deliver to the State each business day, an electronic file containing all forms and specific MDS assessment data that the CONTRACTOR has approved for medical necessity, based on State business rules. Resend lost files to the State within three (3) business days of notification.

LTC - 0074
Forms
Designate a point of contact to respond to State staff on technical issues and questions related to the LTC Online Portal forms processing and LTC claims processing.

LTC - 0076
Forms
Manage and maintain electronic receipt and processing of Minimum Data Set assessments, 3618 and 3619 admissions and discharges to and from Medicare and Medicaid.

LTC - 0241
Forms
Produce reports with volumes and other information related to LTC Online Portal forms and submit to DADS within timeframes, with content and in a media and format approved by DADS.

LTC - 0039
General
Retrieve Minimum Data Set (MDS) assessments from the State MDS database and use to

determine medical necessity. Send the MDS data to DADS within timeframes approved by DADS.

LTC - 0041
General
Accept the Long Term Care Medicaid Information section of the Minimum Data Set assessment from nursing facility providers through the LTC Online portal. Link the data to the correct MDS assessment for the nursing home resident receiving the services.

LTC - 0077
Licensure
Receive and process, up to five (5) times a week, an electronic file that contains Registered Nurse Resource Utilization Group (RUGs) certification status information from the State, or its contracted training entity.

LTC - 0078
Licensure
Validate 100% of the license numbers, as active, used by registered nurses who sign the Minimum Data Set assessments and/or sign the Medical Necessity/Level of Care assessments against the file received from the Texas Board of Nursing and the Nurse License Compact from the State that issued the Nurse Compact License.

LTC - 0080
Licensure
Verify 100% of the registered nurse license numbers on the Minimum Data Set assessment and the Medical Necessity/Level of Care assessment against the Resource Utilization Group certification information provided by the State.

LTC - 0081
Licensure
Validate 100% of the licensure for physicians with the Texas Medical Board that sign medical necessity/level of care and minimum data set forms.

LTC - 0082
Online
Manage and maintain the workflow capabilities of the LTC Online Portal.

LTC - 0083
Online
Correctly process systematic medical necessity determinations as directed by the State.

LTC - 0084
Online
Maintain the following functions on the LTC Online Portal: a) Form Field Validity Checks; b) Audit Architecture; c) Audits; and d) Server edits.

LTC - 0085
Online
Accept the LTC claims management system table updates and apply such updates as directed by DADS.

LTC - 0087
Online
Maintain the Resident Assessment Instrument graphical user interface used to create form user screens on the LTC Online Portal.

LTC - 0091
Online
Maintain current and approved Power Search functionality in the LTC Online Portal.

LTC - 0092
Online
Provide access to data from the LTC Online Portal in a format approved by DADS to State-approved entities.

LTC - 0094
Online
Maintain the ability for all LTC Online Portal users to produce a printable version of each form available on the LTC Online Portal.

LTC - 0095
Online
Maintain the ability for the DADS staff to query data for trend analysis, reporting, and general

searches.

LTC - 0096
Online
Maintain Client Tracking functionality within the LTC Online Portal to enable providers to track the status of form submissions, submission timelines, dependency submission requirements, and form status.

LTC - 0097
Online
Provide a minimum of ten (10) software licenses for project and portfolio management software for the DADS' staff. Provide DADS staff access to contractor's project and portfolio management software.

LTC - 0114
Processing
Accommodate high volume providers (American National Standards Institute [ANSI] and Third-Party Billing Agents) and provide the ability to electronically accept claims in batches.

LTC - 0115
Processing
Receive and process the daily electronic DADS files containing new or changed service authorization and provider data.

LTC - 0116
Processing
Adjudicate claims according to the service authorization and provider files sent by the DADS.

LTC - 0118
Processing
Track, reconcile and report statistics on all LTC administrative payments, which are initiated exclusively by DADS. Submit such statistical report to DADS within the DADS approved timeframes, content, media and format.

LTC - 0119
Processing
Process all retroactive adjustments supplied by DADS. Apply weekly retroactive adjustments for

all LTC services. Maintain sufficient system capacity to process all State retroactive adjustments weekly.

LTC - 0120
Processing
Process adjustments to claims within timeframes approved by DADS.

LTC - 0121
Processing
Maintain all data sets/files, data elements and functions required to support LTC business functions.

LTC - 0132
Processing
Provide 24x7 on-call technical staff to immediately resolve problems with Long Term Care Claims Management System and the LTC Online Portal and related interfaces.

LTC - 0133
Processing
Generate and process monthly Long Term Care claims reconciliation files.

LTC - 0135
Processing
Provide electronic files to DADS daily, containing the status of all files processed (i.e., accepted or rejected and reason for rejection).

LTC - 0136
Processing
Provide payment information to the DADS Health and Human Services Administrative System, within timeframes, with content and in an electronic media and format approved by DADS.

LTC - 0137
Processing
Conduct site visits, within five (5) business days of request, to provider offices as necessary, or when requested by the DADS staff, to assist providers with claims billing or resolve claims processing problems. Provide evidence of each provider site visit, including issue identification

and resolution, to DADS as requested.

LTC - 0138
Processing
Maintain a database with Other Insurance information for use during claims processing.

LTC - 0140
Processing
Maintain the edits in Claims Management System for Long Term Care to determine if there is Other Insurance to bill prior to processing for Medicaid reimbursement for service groups: 1 (Nursing Facilities), 6 (ICF/IID), and 8 (Hospice).

LTC - 0141
Processing
Record Other Insurance information submitted on claims in the Claims Management System for Long Term Care.

LTC - 0142
Processing
Use existing Compass 21 insurance Type of Coverage codes for a minimum of the following insurance policies to cover Long Term Care services: a) Y – Comprehensive Policy; b) N1 – Long-Term Care/Nursing Facility Policy; c) M – Part C Medicare Advantage Plan; d) X – HMO (Health Maintenance Organization) Policy; and e) F – Medicare Supplement Policy.

LTC - 0144
Processing
Re-cycle processed claims if payment related information on a client's other insurance segment is changed.

LTC - 0153
Processing
Maintain, on Provider Support Windows (PSWIN), the pricing for a claim after all Other Insurance edits and pricing processes are executed.

LTC - 0160
Processing
Maintain the TMMIS data repository to load pricing information for paid claims, including cost

avoided amounts, to allow pricing information to be accessed via the online ad hoc reporting system.

LTC - 0161
Processing
Maintain the TMMIS data repository Long Term Care information to load Explanation of Benefits information for claims denied as a result of missing Other Insurance information to allow access via the ad hoc reporting system.

LTC - 0162
Processing
Maintain the TMMIS data repository to load all Other Insurance segments/information from Claims Management System to be viewed via the ad hoc reporting system.

LTC - 0165
Processing
Maintain and track Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions' client hold data.

LTC - 0169
Processing
Maintain the TMMIS data repository to include the list of Service Group values in the ad hoc reporting system, reports and extracts.

LTC - 0171
Processing
Maintain the TMMIS data repository to load LTC client hold data elements in the LTC information and maintain in Claims Management System to allow the information to be accessed via the ad hoc reporting system.

LTC - 0244
Processing
The contractor is responsible for forwarding authorization data to Managed Care Organizations when appropriate for MCOs use in adjudication.

LTC - 0176
Publications

Maintain and update the electronic help file, comprised of claims processing procedures for LTC providers who submit electronic claims.

LTC - 0184
Reporting
Provide a monthly report to the Health and Human Services Commission on the LTC operations within the agreed upon timeframes and with the approved content, media and format.

LTC - 0186
Reporting
Produce federal waiver data sheets annually for the lag waiver year that includes counts and expenditures for waiver, non-waiver, and institutional waiver recipient populations, acute care costs and expenditures and follow the existing waiver data sheet business rules as defined by the DADS.

LTC - 0208
Resources
Maintain twelve (12) LTC technical full-time equivalents (FTE) to plan, develop and implement the DADS projects. Assign a dedicated Portfolio Lead to serve as a technology liaison for DADS.

LTC - 0209
Resources
Schedule and prioritize work for twelve (12) dedicated technical FTEs according to system enhancement priorities determined by DADS for LTC projects.

LTC - 0213
Resources
Use licensed Registered Nurses for 100% of medical necessity determinations for the DADS LTC programs.

LTC - 0001
Service Determination
Provide medical necessity status information and assistance to providers, Medicaid applicants, Medicaid individuals and HHSC Medicaid Eligibility Workers, within State-approved timeframes.

EXHIBIT B
Attachment 22
Long Term Care (LTC)

LTC - 0003
Service Determination
Review Nursing Facility (NF) Customized Power Wheelchair (CPWC) Authorization requests within three (3) business days of receipt.

LTC - 0005
Service Determination
Use a State-approved process and procedure to contact the nursing facility, Customized Power Wheelchairs (CPWC) Durable Medical Equipment provider or therapist to gather additional information required to complete the authorization requests initially "pended" within timelines approved by DADS.

LTC - 0006
Service Determination
Generate letters regarding authorizations of Customized Power Wheelchairs (CPWC) requests to the nursing facility and the nursing facility resident or the resident's responsible party with content and in a media and format approved by DADS.

LTC - 0053
Service Determination
Prior to placing an MDS in pending denial the CONTRACTOR Registered Nurse must review an active PASRR Evaluation (PE) when available.

LTC - 0214
Service Determination
Determine medical necessity for individuals initially and upon submission of any complete Minimum Data Set assessment, Medical Necessity and Level of Care assessment, and preadmission PASRR evaluation within five (5) business days of receipt.

LTC - 0215
Service Determination
For assessments for which additional information was requested, make the medical necessity determination within five (5) business days of the date of receipt of additional information necessary to complete the Minimum Data Set assessment, Medical Necessity and Level of Care assessment, and preadmission PASRR evaluation.

LTC - 0217
Service Determination
Provide the system capability to accept Resource Utilization Group calculation data from Minimum Data Set for the nursing facility program.

LTC - 0219
Service Determination
Accept and process assessments and client movement data. Verify eligibility for level of care for clients enrolled in the Intermediate Care Facilities for Individuals with Intellectual Disabilities program.

LTC - 0220
Service Determination
Auto-approve continued stay reviews for assessments in accordance with DADS approved eligibility criteria for Intermediate Care Facility for Individuals with Intellectual Disabilities.

LTC - 0221
Service Determination
Make available to DADS for final approval Intermediate Care Facility for Individuals with Intellectual Disabilities assessments that cannot be auto-approved.

LTC - 0223
Service Determination
Accept Minimum Data Set and medical necessity/level of care assessments from out-of-State providers that have a contract with the DADS.

LTC - 0240
Service Determination
For pended Nursing Facility (NF) Customized Power Wheelchair (CPWC) Authorization requests, the CONTRACTOR will make the final determination no later than twenty-one (21) calendar days from the date the request was pended.

LTC - 0011
Support
Provide onsite support staff at the DADS offices to resolve problems as requested.

EXHIBIT B
Attachment 22
Long Term Care (LTC)

LTC - 0013
Support
Provide authorized State staff with the same online access to claim information as provided to CONTRACTOR personnel on the Long-term Care toll-free telephone lines.

LTC - 0014
Support
Designate an individual as the primary DADS contact for discussions of all LTC matters. This individual is required to attend monthly meetings with DADS staff to evaluate performance and to discuss upcoming activities and issues.

LTC - 0024
Support
Identify and upload commercial health insurance policies with specific potential coverage for LTC services for new and existing LTC clients on a monthly basis.

LTC - 0026
Support
Identify and upload any new or changed commercial insurance policy information semi-annually (twice a year, at six (6) month intervals) for all DADS LTC clients being served by the LTC Nursing Facility, Hospice, and non-State operated Community ICF/IID programs.

LTC - 0028
Support
Update an insurance segment when new information is obtained for DADS LTC clients as defined by the State including:

a) Relationship;
b) Subscriber Name;
c) Subscriber Social Security Number;
d) Subscriber Number;
e) Subscriber Date of Birth;
f) Group Number;
g) Type of Coverage;
h) Effective Dates; and
i) Comments (such as policy limitations or restrictions).

EXHIBIT B
Attachment 22
Long Term Care (LTC)

LTC - 0245
Training, Education and Materials
Training and educational activities and materials must be timely and comprehensive, in support of the HHSC and DADS approved program goals and objectives.

LTC – 0246
Service Determination
Conduct medical necessity determinations, in accordance with HHSC approved processes and procedures, for the STAR Kids and STAR Health MDCP populations with STAR Kids and STAR Health plan codes, based upon receipt of the MDCP Module of the STAR Kids SAI from STAR Kids MCOs and the STAR Health MCO.

LTC - 0247
Service Determination
Conduct medical necessity determinations, in accordance with HHSC approved processes and procedures, for CFC services for clients with STAR Kids plan codes, based upon receipt of a CFC trigger in the STAR Kids SAI from STAR Kids MCOs.

EXHIBIT B
Attachment 23
Management and Administrative Reporting (MAR)

MAR - 0006
General
Respond to all State requests for information about MARS reports no later than three (3) business days after receipt of the request.

MAR - 0008
General
Compare the data created in support of the MARS functionality against reports generated from TMMIS (e.g., selected claims and financial reports).

MAR - 0009
General
Notify the State within one (1) business day of any variances between MARS produced reports and the data generated in TMMIS.

MAR - 0011
General
Clearly define and recommend to the State changes or additions to State and federal categories of service including but not limited to eligibility categories, provider taxonomy, accounting codes, and other codes necessary for producing MARS reports.

EXHIBIT B
Attachment 24
Medical and Dental Policy (MDP)

MDP - 0001
General
CONTRACTOR and/or Subcontractor medical and dental policy staff will perform activities associated with updates and implementation of medical/dental benefit policies for all State programs as directed by the State in relation with International Classification of Diseases (ICD),Healthcare Common Procedure Coding System (HCPCS), and Current Procedural Terminology (CPT), Current Dental Terminology updates, and National Correct Coding Initiative (NCCI).

MDP - 0007
General
Participate in the medical/dental policy development meetings, as directed by the State.

MDP - 0070
General
Perform a QA survey of the final draft policy information by all CONTRACTOR departmental areas (*e.g.*, Medical Policy Support, RDM, Claims, Technology, DRT, etc.) participating in policy development.

MDP - 0071
General
Maintain subscriptions to service(s) that provide evidence-based peer reviewed literature on medical services and devices. Provide access to State-approved staff.

MDP - 0073
General
Provide accurate information to the State related to medical/dental policy during the policy development process.

MDP - 0074
Policy Implementation
Submit inquiries and/or questions related to the categorization of the medical policy review (comprehensive, targeted, language only) within one (1) week of the received date of the review request in correspondence in MCATS.

EXHIBIT B
Attachment 24
Medical and Dental Policy (MDP)

MDP - 0075
Policy Implementation
Maintain and report updates to Clinical Policy on the Master Medical Policy spreadsheet with associated Medical Policy Support PPM ID number in a format, with content, and frequency specified by the State.

MDP - 0014
Publications
Submit medical/dental policy manuals additions, changes, and deletions to the appropriate State program for review and approval before incorporation into the medical/dental policy manuals in a timeframe, media, and content as defined by the State.

MDP - 0015
Publications
Maintain provider procedures manuals that are consistent with the medical/dental policy manuals.

MDP - 0018
Publications
Distribute State-approved policy revisions and associated rate changes to State-approved business partners in an electronic format (45) calendar days before the operational implementation, or as directed by the State.

MDP - 0029
Research, Analysis and Development
Support the State's development of medical/dental policy related to coding changes (*i.e.*, HCPCS, ICD, NCCI) by providing:

a) A concise description of the findings and policies impacted;

b) Clinical research including references to peer-reviewed medical/dental policy literature and publications;

c) Research from Medicare, other federal and State agencies, commercial insurance carriers, and appropriate professional organizations;

d) Claims information as requested;

e) Administrative impact analysis of TMMIS and other State-approved business partners, and a prudent estimate of the costs associated with this impact; and

f) The policy implementation plan and timeline approved by the State.

MDP - 0031
Research, Analysis and Development
Provide information upon request to HHSC-SDS to support Estimated Client Services Fiscal Impact (ECSFI), Utilization Review and Post Implementation Utilization Review development to allow a continuation of the collaborative Medical Policy Review process.

MDP - 0037
Research, Analysis and Development
Document activities related to coding work (*i.e.*, HCPCS, ICD, NCCI) in a format and in a timeframe approved by the State.

MDP - 0038
Research, Analysis and Development
Obtain written approval from assigned State staff on timelines for medical/dental policy implementations.

MDP - 0041
Research, Analysis and Development
Jointly review Medical/Dental processes and procedures (including development process charter review and RACI documents) at least annually, or as directed by the State.

MDP - 0045
Research, Analysis and Development
Support the State's development of medical/dental policy by analyzing potential system and operational impacts related to all State medical/dental policy changes and providing a prudent estimate of the costs associated with the impact; providing claims information as requested, and recommending an implementation plan of action based on timeframes, media, and content as defined by the State.

MDP - 0047
Research, Analysis and Development
Define, plan, and manage all Medical/Dental project activities related to coding changes (i.e., HCPCS, ICD, NCCI) to ensure that State-approved timelines are established and met, progress is tracked and reported to the State, and quality control checks are implemented to achieve project

objectives.

MDP - 0050
Research, Analysis and Development
Medical/Dental policy development support and operational implementation must be in accordance with, and consistent with, the scope, benefits, exclusions, and limitations of the Medicaid program, CSHCN Services Programs and other Texas programs, and must be approved by the State.

MDP - 0056
Research, Analysis and Development
Identify and provide a report of Medical/Dental policies impacted by coding changes (i.e., HCPCS, ICD, NCCI) within timeframes and in a format and content approved by the State.

MDP - 0058
Research, Analysis and Development
Update medical and dental policies with coding recommendations (e.g., NCCI, HCPCS, and ICD) as directed by the State and within timelines approved by the State.

MDP - 0060
Research, Analysis and Development
Review and assess impacts of CMS required code set migrations (e.g., ICD-9 to ICD-10, HCPCS, etc.) on Medical/Dental policies, and submit to each program for approval prior to implementation.

MDP - 0061
Research, Analysis and Development
Lead and participate in the ICD-10 Migration Analysis Workgroups by comparing the codes to the General Equivalence Mappings (GEMs), along with recommendations provided in a State-approved coding management tool, to document the prioritized mapping decisions.

MDP - 0062
Staffing
Provide an ICD-10 certified coder with broad current outpatient billing/coding experience to assist in operationalizing medical policy development related matters or other projects as specified by the State. The certified coder must demonstrate competency in the knowledge and

skills specified.

MDP - 0067
Staffing
Ensure that the CONTRACTOR's Senior Medical Director reviews specific analysis provided to the State medical/dental policy team to ensure accuracy of research before submission to the State.

MDP - 0069
Staffing
The CONTRACTOR's Medical Director/Dentist and physician staff must participate in and be able to provide input and clinical analysis on specific policies which they support, during the medical/dental policy development process, including the medical/dental policy development meetings.

EXHIBIT B
Attachment 25
Medical Transportation Program (MTP)

MTP - 0008
General
Provide dedicated, qualified, experienced, and knowledgeable staff for Non-Emergency Medical Transportation (NEMT) technology support.

MTP - 0024
General
Obtain MTP written approval prior to disenrollment of any MTP provider that is listed on the exclusion list.

MTP - 0068
General
Complete all processing related to MTP fee-for-service run out, appeals, audit activities, provider enrollment, rates, and any other historical data maintained by CONTRACTOR to include research and ad hoc support for historical MTP FFS claims processing as requested by the State.

MTP - 0071
General
Create and maintain a Medical Transportation Identifier (MTI) for MTOs, MTO subcontractors, and providers in MTO provider networks.

Maintain and track Medical Transportation Identifiers (MTIs) issued by the MTOs and FRBs for MTO/FRB subcontractors and Individual Transportation Participants (ITPs) enrolled through their own networks.

MTP - 0074
General
Enroll MTP Full Risk Brokers (FRBs), FRB subcontractors, MTOs, and MTO subcontractors using the MTP-specific provider enrollment application integrated into the MMIS.

MTP - 0030
Processing
Respond to queries, written or verbal, on enrollment to HHSC or NEMT provider within two (2) business days.

MTP - 0049
Processing
Identify medical service claims, or encounters with client ID numbers, and date of service that match the fee-for-service medical transportation claim in a paid status, and automatically link the medical services claim and/or corresponding medical, dental or pharmacy claims and MCO encounter claim number to the NEMT claim record.

MTP - 0058
Processing
Maintain an automated file transfer process for NEMT data extracts, by program, and send to the State, with content, and in a format approved by the State.

MTP - 0069
Processing
Identify healthcare service claims, or MCO encounters with client ID numbers, and date of service that match the MTO/FRB NEMT encounter record and automatically link the healthcare services claim or MCO encounter claim number to the MTO/FRB NEMT encounter record.

MTP - 0070
Processing
Process and validate provider network files submitted by Medical Transportation Organizations (MTOs) and FRBs on a daily basis and provide results to the MTOs/FRBs of their provider network files to include HHSC driver's license checks.

MTP - 0072
Processing
Provide data and reports to HHSC to support audits of MTO and FRB processing (e.g., provider enrollment and MTO/FRB encounter data) to include, MTO/FRB encounter records and supporting data in State required extracts such as MFADS and Transformed Medicaid Statistical Information System (T-MSIS).

MTP - 0073
Processing
Match MTO encounters to medical service claims or encounters on a monthly basis. Provide supporting matching reports and an ad hoc reporting environment for matching results.

MTP - 0075
Processing
Provide and maintain a secure FTP environment to exchange data with HHSC, MTOs and FRBs as defined by the State.

MTP - 0076
Processing
Provide a weekly extract of active medical, pharmacy and MTP providers to MTOs and FRBs.

MTP - 0077
Processing
Provider trading partner support to MTOs and FRBs as such trading partner testing, companion guides, and help desk support to facilitate MTO/FRB provider network and encounter data submission.

MTP - 0078
Processing
Process and validate encounter records submitted by MTOs and FRBs on a daily basis and provide results to the MTOs/FRBs of their encounter files.

MTP - 0079
Processing
Provide and maintain an ad hoc query platform for State users to query MTO/FRB provider network, MTO/FRB encounter data and other MTP data for trend analysis, reporting and targeted searches, and program administration and quality monitoring activities.

MTP - 0080
Processing
Provide MTP with a monthly report on MTO/FRB encounter activity (received, rejected, reprocessed, etc.).

MTP - 0081
Processing
Maintain MTO and FRB subcontractor rate tables leveraging subcontractor enrollment. Use the information provided to cross-check against encounter records to identify anomalies.

MTP - 0082
Processing
Verify Medicaid/CSHCN/TICP eligibility. Cross-check the TIERS eligibility file sent by HHSC against the MTO/FRB encounter records.

MTP - 0083
Processing
Convert the vehicle identification number (VIN) entry on the 837P encounter file reported in the "Comment" field to a required data element that can be used to cross-check the information submitted against other data sets to validate entry.

MTP - 0084
Processing
Maintain and track vehicle identification number and vehicle type submitted by the MTOs/FRBs. Use the information submitted to cross-check against the MTO/FRB encounter records and report anomalies to HHSC in a report format and media approved by HHSC.

MTP - 0085
Processing
Maintain a MTP Encounters Business Object Universe that represents a full history of data elements loaded into the Data Warehouse from Managed Transportation Organizations (MTOs) and Full Risk Brokers (FRBs) for 837 Professional Encounters with access limited to organizations or staff as approved by MTP Executive Management staff in writing.

MTP - 0086
Processing
Load data elements for the MTO/FRB encounters processed up to two (2) days prior to the current date to include all versions of the encounter (including reversals and voids).

MTP - 0087
Processing
Reallocate expense and track all Mass Transit Usage claims in the STAT/Voucher from 100% State to 60/40 Federal match when a medical match is made up to 365 days from the date of service or if there is a claim form (H3018) on file. Store an indicator in Vision 21 for why funds are moved from 100% State to 60/40 for auditing and querying purposes.

MTP - 0088
Processing
Provide training to the MTOs/FRBs on reporting unit counts as prescribed by MTP by service category on the 837 P file.

MTP - 0089
Processing
Validate entry on the MTO/FRB 837 P file of a Shared Ride Service Indicator when the cost equals zero and link encounter record to the corresponding healthcare record with cost reported.

MTP - 0090
Processing
Generate MTO/FRB encounter file(s) for CSHCN data extract for MTO/FRB encounter data.

MTP - 0091
Processing
Send the MTO/FRB encounter file(s) to HHSC via a SFTP on a monthly basis due by the 10th business day of the month following the month the transmission file is received from the MTO/FRB.

EXHIBIT B
Attachment 26
Medically Needy Program (MNP)

MNP - 0001
Communications
Obtain a post office box to be used exclusively for the Medically Needy Program.

MNP - 0004
Communications
Prevent duplicate files in the Medically Needy Program electronic inquiry system by identifying previous case numbers prior to entry into the system.

MNP - 0005
Communications
Notify Medically Needy Program clients of case status when the spend-down is met, the case is closed or it goes into a hold.

MNP - 0006
Communications
Mail State-approved letters to clients within two (2) business days after determining the status of a Medically Needy Program case. "Spend-down met" letters must list: Each bill used to meet spend-down, and notify the applicant of responsibility for these bills; Bills for which provider must send in a State-approved claim form to the CONTRACTOR's claims processing area; and each claim that will be forwarded to the CONTRACTOR's claims processing area for possible payment.

MNP - 0007
Communications
Contact providers to obtain missing information on Medically Needy Program bills or State-approved claim forms and notify providers when they need to submit a CMS claim form using content, media, and format as approved by the State.

MNP - 0008
Communications
Research issues and respond to inquiries from Medically Needy Program or the State within two (2) business days of receipt, or as specified by the State. Provide responses with content, and in a media, and format approved by the State.

EXHIBIT B
Attachment 26
Medically Needy Program (MNP)

MNP - 0015
Data and Document Retention
Maintain Medically Needy Program referral file data containing changes that must be evaluated to determine the effect of the change (case rework or informational).

MNP - 0017
Processing
Update the Medically Needy Program inquiry system within one (1) business day of case review completion.

MNP - 0021
Processing
Process Medically Needy cases within the following timelines: a) Process and complete 90% of all spend down cases within 29 calendar days of initial receipt of bills or State-approved claim forms, whichever is earlier; and b) Process 100% of all spend down cases within 55 calendar days of initial receipt.

MNP - 0022
Processing
Reactivate Medically Needy cases when additional bills, corrected bills, or State-approved claim forms are received.

MNP - 0023
Processing
Process Reactivated Medically Needy cases within the following:

a) Process and complete 90% of reactivated cases within twenty (20) business days; and

b) Process and complete the remaining 10% of reactivated cases within thirty (30) business days of reactivation.

MNP - 0026
Processing
Provide electronic capability to track and report spend-down levels.

MNP - 0028
Processing
Enter all bills and State-approved claim forms into the Medically Needy Program system within

one (1) business day of receipt.

MNP - 0030
Processing
Send completed Medically Needy Program referrals to State eligibility systems daily for processing.

MNP - 0032
Processing
Process medical and/or dental bills in accordance with State-approved processes and procedures for the Medically Needy Program.

EXHIBIT B
Attachment 27
Office of the Attorney General (OAG)

OAG - 0015
General
Designate an analyst to run data requests identified by the State as intended for discovery production. The analyst must have no knowledge or awareness of the development and formulation process that preceded submission of final data requests associated with investigation or litigation.

OAG - 0016
General
Designate an individual to serve as a qualified testifying witness for litigation and investigations as well as provide affidavits and any other litigation-related documentation, as needed regarding how a state-requested query was run. This individual should be a different individual from the point of contact for informational requests and from the DSS Analyst, and will be identified on an as needed basis.

OAG - 0017
General
Obtain approval for designated testifying witness from the State within designated timeframes.

OAG - 0018
General
Provide staff that are experienced, knowledgeable, and qualified to testify in formal or informal adjudicative proceedings about the data base(s) used in running OAG data requests such that the witness(es) can both explain how the data requests were run as well as what data that query has captured and any other matters on which testimony is required by OAG.

OAG - 0019
General
Provide a designated resource to respond to specific requests, including email archive requests, and needs of the OAG, within the individually specified timelines, outlined in each OAG request submitted to the CONTRACTOR regarding the investigation and prosecution of fraud, abuse, or waste in the Texas Medicaid program.

OAG - 0020
General
Update OAG with new contact information within ten (10) calendar days of any change to the

designated points of contacts or any identified backups, as necessary due to personnel changes.

OAG - 0021
General
Prohibit designated testifying witnesses from discussing or otherwise sharing information regarding the specific investigation or litigation matter(s) and/or the preliminary analysis in any manner or through any medium other than designated State legal counsel. This prohibition includes discussion with staff that has run preliminary analysis.

OAG - 0022
General
Take reasonable steps to ensure that the testifying witness will have no knowledge nor be aware of the development and formulation process that preceded submission of the "final" query via SAR.

OAG - 0023
General
Designate an individual and backup knowledgeable of litigation and discovery to be responsible for receiving and executing notice of litigation or investigations from HHSC or OAG, executing litigation holds, and responding to investigational or discovery requests and other related inquiries within ten (10) calendar days.

OAG - 0024
General
Instruct CONTRACTOR staff and subcontractors that they must maintain the confidentiality, including internal confidentiality, of all matters under investigation or litigation by the State.

OAG - 0025
General
Store, archive, and make accessible all records, including email, involved in any litigation until the State requests the destruction or return of the records.

OAG - 0031
General
No claims history related documents or data should be destroyed or purged without prior coordination with HHSC and written approval from an authorized HHSC employee. In the event the retained claims history approaches storage capacity, CONTRACTOR needs to notify HHSC

and offer storage capacity options such as expanded capacity funded through a change order.

OAG - 0026
Litigation Support
Support litigation and/or administrative hearing activities (e.g., by providing testimony, documentation, etc.), as required by the State.

OAG - 0027
Litigation Support
Supply all reports, files, copies, and other documentation requested by the State, Department of Justice (DOJ) or other federal entities to support their prosecution or defense of lawsuits.

OAG - 0028
Litigation Support
In support of pending litigation, and as requested by the State, analyze the data and provide the initial and final results to HHSC or its designee.

OAG - 0029
Litigation Support
Assist the State in due diligence required for paper and/or electronic discovery obligations that arise in litigation. Assist the State and/or the OAG in litigation document retention holds, as instructed by the State and/or the OAG.

OAG - 0030
Litigation Support
Strictly comply with all litigation holds issued by the State.

EXHIBIT B
Attachment 28
Prior Authorization and Referral Management (PAC)

PAC - 0028
Correspondence
Prepare and distribute PA materials and publications within timelines, with content, and in a media, and format approved by the State.

PAC - 0030
Correspondence
Provide to clients and providers a written, detailed explanation of the rationale for any PA service reduction, modification, or denial, including information regarding the appeal process or fair hearings, and timeframes for filing.

PAC - 0031
Correspondence
Client notification must be written in both Spanish and English, at the 4th to 6th grade reading level.

PAC - 0032
Correspondence
Notify providers of the PA determination one (1) business day after the final disposition (e.g., approved, denied, modified, voided, duplicated, or determined incomplete) of the PA request.

PAC - 0033
Correspondence
Produce and transmit/mail final PA determination notification letters to clients and providers using State program approved templates.

PAC - 0034
Correspondence
Notification to a provider, including the determination and PA number, may be transmitted by phone or fax, however, notification to the client must always be provided in a letter.

PAC - 0035
Correspondence
Retain an electronic copy of each PA determination notice letter on the PA system.

EXHIBIT B
Attachment 28
Prior Authorization and Referral Management (PAC)

PAC - 0036
Correspondence
Conduct annual reviews of the content of PA notification templates to determine if the notices require updating. Make recommendations for modifications of PA notification letters (with associated cost estimates) or develop new PA notifications when business needs dictate. Obtain State approval for the content and format of all PA notifications for providers and clients.

PAC - 0039
Correspondence
Notify the provider by letter when the PA request is determined to be incomplete, send the letter within three (3) business days of receipt of the PA request, requesting the information necessary to make the PA determination.

PAC - 0040
Correspondence
Allow four (4) business days from the date of the provider notification letter for the provider to return the information necessary to complete the PA request. Make no less than three (3) documented attempts to call and/or fax the provider to obtain the required information to complete a PA request. If the requested information is not received from the provider by the end of the fourth business day, send a letter to the client, within one (1) business day, stating that the PA request cannot be processed until the provider responds with the information necessary to complete the PA request. Include with the client notification letter, a copy of the initial provider notification letter listing the specific information necessary to make the PA determination.

PAC - 0003
General
Retain and retrieve all PA records consistent with HHS Records Management Policy and Retention Schedule. The PA records include, in any format, but are not limited to, all current, stored and archived document inventory, internal and external correspondence of any kind, claims and supporting documentation of any kind (including diagnostics, requests, reports, forms, tools, photographs, research, and claims information), all Prior Authorizations (PA) information and processes, determinations of any kind, and all memorandum regarding the PA requests.

PAC - 0024
General
Only use qualified Texas licensed physicians and dentists to perform clinical reviews on medical

necessity determinations completed by physician/dentist.

PAC - 0099
General
If the personnel or analyst are subject to licensure by the State of Texas for prior authorization (PA) activities, then such individuals must be so licensed unless an exception is granted by the State.

PAC - 0053
Processing
Enter all prior authorization dispositions into the prior authorization system immediately upon disposition.

PAC - 0054
Processing
Submit to the State for final determination any proposed exceptions to prior authorization requirement, including, but not limited to, exceptions related to Alberto N. litigation.

PAC - 0055
Processing
Forward preliminary determinations for requests not meeting medical policy to CONTRACTOR's Medical Director/Dentist to review for final disposition of service request in a timeframe specified by the State. Dental determinations will be reviewed by CONTRACTOR's Dentist for final disposition of request, per the Dental Practice Act.

PAC - 0056
Processing
With the exception of administrative (also referred to as "technical") denials, the CONTRACTOR will forward to the CSHCN Services Program no less than 98% of the CSHCN recommended dental requests not meeting CSHCN policy per dentist reviewer within one business day of the recommendation.

PAC - 0057
Processing
Disposition (e.g., approve, deny, modify, void, or duplicate) of prior authorization requests within forty-eight (48) hours of receipt of all requests for non-emergency ambulance services.

PAC - 0058
Processing
Ensure that prior authorization requests are for covered services only, unless the State specifically directs otherwise.

PAC - 0059
Processing
Provide dedicated fax capability for medical and dental PAs with the capacity to receive and process all incoming PA requests/transmissions according to State-approved processing timelines.

PAC - 0061
Processing
Apply and document PA decisions in accordance with State-approved PA decision making criteria and State-approved processes and procedures.

PAC - 0065
Processing
Accept and process prior authorization requests in any medium approved by the State.

PAC - 0066
Processing
Train relevant staff, or as directed by the State, on the requirements of litigation agreements (e.g., Frew v. Smith and Alberto N. settlement agreements) using a State-approved training curriculum. Provide documentation to the State on the 15th business day of the following month on the training provided and names of the staff trained during each proceeding month.

PAC - 0095
Processing
Maintain a listing of stem cell transplant centers, updated monthly, that are enrolled in the CSHCN Services Program for reference in prior-authorizing stem cell transplants.

PAC - 0097
Processing
For prior authorization service requests, with the exception of non-emergency ambulance requests, that require physician or dentist review, document a final determination (e.g., approve, modify or deny) no later than three (3) business days of receipt of complete information by the

reviewing physician or dentist, or no later than six (6) business days when a peer-to-peer contact to the treating physician/dentist is required.

PAC - 0098
Processing
With the exception of administrative (also referred to as "technical") denials, the CONTRACTOR will forward to the CSHCN Services Program no less than 98% of the CSHCN recommended medical requests not meeting CSHCN policy within one (1) business day of the recommendation. The CONTRACTOR will forward to the CSHCN Services Program 100% of the CSHCN recommended medical requests not meeting CSHCN policy within two (2) business days of the recommendation.

PAC - 0100
Processing
Use qualified therapists to review all physical, occupational, and speech therapy requests for clients who are requesting therapy services for the first time and therapists will review other clinicians' approvals for therapist services that are twice a week or more or who have not received therapy services for three or more years.

PAC - 0083
Service Determination
Provide PA medical criteria within three (3) business days upon receipt of request from the provider as directed by the State.

PAC - 0090
Staffing
Provide and maintain knowledgeable and professional medical and dental personnel to perform the PA tasks and responsibilities. PA personnel must include: a) PA analysts to process requests; and b) State of Texas licensed clinical, medical, and dental professionals acting within their scope of practice as established by their respective board.

PAC - 0091
Staffing
Maintain a current record of individuals performing each task or function of the PA program including the individual's qualifications and licensure. Submit an up-to-date copy of the record in a reporting format approved by the State on the last business day of each month.

EXHIBIT B
Attachment 29
Provider (PRV)

PRV - 0045
Communications
Distribute program specific form letters and templates within prescribed timeframes and in accordance with State guidelines.

PRV - 0046
Communications
Develop issue specific letters and distribute as directed by the State.

PRV - 0047
Communications
Develop accurate and complete program specific forms in accordance with the process and procedures approved by the State.

PRV - 0048
Communications
Post State-approved program specific forms on the CONTRACTOR's website and make copies available in provider publications.

PRV - 0049
Communications
Perform a semi-annual review of all letters and templates to ensure accuracy, consistency, and completeness.

PRV - 0050
Communications
Notify the State in writing upon completion of semi-annual review of letters and templates and secure State approval for any recommended changes.

PRV - 0051
Communications
During the approval process, ensure all updates of letters and templates are dated and formatted so that it is apparent to the reader what changes are being recommended.

PRV - 0417
Communications
Produce and mail one (1) annual letter to HTW providers, with content approved by HHSC.

PRV - 0015
Electronic Health Records
Distribute applicable Electronic Health Record (EHR) incentive payments amounts for eligible providers using data received via attestation and/or from the TMMIS based on predetermined rules including systematically tracking assignment and change of assignment by National Provider Identifier (NPI).

PRV - 0016
Electronic Health Records
Make Electronic Health Record (EHR) incentive payment information available through the dashboard suite including:

a) Payment Summary Report;

b) Aggregated Meaningful Use Data Report;

c) Audit Activity Report;

d) Provider Audit Report; and

e) Provider Dispute Report.

PRV - 0017
Electronic Health Records
Collect current Electronic Health Record (EHR) meaningful use data, from attestation and the National Level Repository (NLR), which includes functions that:

a) Produce the Clinical Quality Measures Data Report at the aggregate level;

b) Support the ability to collect federal and State required meaningful use and clinical quality measures;

c) Identify those Eligible Professional (EP) and Eligible Hospital(s) (EH) that are meeting/not meeting meaningful use criteria at the aggregate level; and

d) View meaningful use aggregate data submitted by the EP/EH.

PRV - 0018
Electronic Health Records

EXHIBIT B
Attachment 29
Provider (PRV)

Provide up to ten (10) Electronic Health Record (EHR) Provider Incentive Program reports, which leverage current MI360 reporting delivery and data retrieval mechanisms.

PRV - 0019
Electronic Health Records
Conduct Gap Analysis of Electronic Health Record (EHR) "meaningful use" as required by the State for various stages as defined by CMS.

PRV - 0040
Electronic Health Records
Follow the Electronic Health Record (EHR) Incentive Program Dispute Resolution plan for resolving disputes.

PRV - 0041
Electronic Health Records
Refer escalated Electronic Health Record (EHR) appeals regarding the EHR Incentive eligibility or payment appeals directly to the State Health Information Technology (HIT) program within three (3) business days of receipt in the appeal queue.

PRV - 0042
Electronic Health Records
Provide Electronic Health Record (EHR) Incentive Program dispute resolution services for providers.

PRV - 0043
Electronic Health Records
Manage the first level Electronic Health Record (EHR) Incentive Program provider appeals in accordance with State-approved policies and procedures and timelines.

PRV - 0044
Electronic Health Records
Update the Electronic Health Record (EHR) Incentive Program Desk Audit Policies and Procedures annually and as frequently as needed to reflect the Desk Audit Determination Criteria.

PRV - 0106
Electronic Health Records

EXHIBIT B
Attachment 29
Provider (PRV)

Use attestation information to deem in certain qualified providers for the Electronic Health Record (EHR) incentive payment as directed by the State.

PRV - 0107
Electronic Health Records
Maintain an Electronic Health Record (EHR) Incentive Payment Provider Eligibility and Attestation web portal to include components that determine EHR Incentive program eligibility by eligible provider type based on federal regulations.

PRV - 0108
Electronic Health Records
Maintain an Electronic Health Record (EHR) Incentive Payment Provider Eligibility and Attestation web portal to include components that generate an email response to providers to notify them of eligibility and attestation status.

PRV - 0109
Electronic Health Records
Maintain connection with the CMS National Level Repository (NLR) including the following functions: Validate Electronic Health Record (EHR) Incentive provider eligibility based on data received from the NLR.

PRV - 0110
Electronic Health Records
Maintain connectivity with the CMS National Level Repository (NLR) including Electronic Health Record (EHR) Incentive Program functions that track changes in a provider's designation of State or Medicare / Medicaid program participation.

PRV - 0111
Electronic Health Records
Maintain system processes to support verification of providers for the use of certified Electronic Health Record (EHR) technology and other eligibility criteria including functions to determine, with State approval, and track which providers are verified.

PRV - 0062
Enrollment
Enroll/Re-enroll providers per State-approved processes and procedures.

PRV - 0064
Enrollment
Perform and maintain procedures for accurate enrollment, verification of licensing and certification information for providers as agreed to by the State.

PRV - 0065
Enrollment
Verify prospective provider(s) and their business owner(s), at time of enrollment and re-enrollment, are not excluded or prohibited from participation in State and/or Federal Healthcare Programs as identified electronically on available federal databases, and State databases including but not limited to State List of Excluded Individuals and Entities (LEIE), State Do Not Enroll (DNE) and State Open Investigations (OIL) or as otherwise required by the State.

PRV - 0066
Enrollment
Verify prospective provider(s) physical and billing address, Social Security Number, and tax ID are not associated with any providers identified on any State and/or Federal Healthcare sanctions list.

PRV - 0067
Enrollment
Refer prospective provider applications to HHSC Medicaid Program Integrity (MPI) when prospective provider or affiliated data appears on State and/or Federal Healthcare sanctions list.

PRV - 0068
Enrollment
Prior to enrollment and on an ongoing basis, verify that the provider is Medicare enrolled (if required), licensed and certified for procedures for which they will be billing under their enrolled specialty.

PRV - 0069
Enrollment
Maintain documented evidence of Medicare enrolled verification for each qualifying factor within the Provider's file.

PRV - 0070
Enrollment

Allow for the enrollment and payment of State-approved out-of-state providers in accordance with State direction.

PRV - 0071
Enrollment
Archive the original provider application and all supporting documents in accordance with State-approved policies and procedures or as directed by the State when a provider record is created or modified in the TMMIS.

PRV - 0072
Enrollment
Retain all provider applications and agreements in electronic form for each provider enrolled in programs, prior to actual enrollment.

PRV - 0074
Enrollment
Track electronically all requests received for provider enrollment materials, provider eligibility criteria and related instructions.

PRV - 0075
Enrollment
Furnish requested provider enrollment information within three (3) business days of receipt of the request or as directed by the State.

PRV - 0076
Enrollment
Prepare monthly reports summarizing provider enrollment information requests and disbursements by program, activity and date(s). Reports must be submitted to the State by the 20th calendar day of the following month, with content in a media and format approved by the State.

PRV - 0077
Enrollment
Review all provider applications, identify all deficiencies present in the application, and mail one (1) letter or respond to the provider via State-approved communication process detailing all deficiencies within five (5) business days of receipt of the application.

PRV - 0079
Enrollment
Complete the processing of the incomplete enrollment applications (within five (5) business days) upon receipt of the necessary information.

PRV - 0080
Enrollment
Notify each provider within two (2) business days of identifying that the response to a provider application deficiency notice does not clear the application of deficiencies via State-approved communication process. Phone call (date, comprehensive summary of conversation with provider and outcome) must be documented in the CONTRACTOR's automated tracking system.

PRV - 0081
Enrollment
Notify program applicants, via State-approved delivery methods, of continued deficiencies in the provider application within two (2) business days following unsuccessful attempts for contact via telephone.

PRV - 0082
Enrollment
Inform the provider within two (2) business days of auto closure of the enrollment application for provider non-responses to the deficient notification.

PRV - 0083
Enrollment
Communicate via a State-approved process with each provider with open, submitted provider applications within ten (10) business days prior to the thirty (30) business day auto-closure to assist with issue resolution, or confirm and document their intent not to continue with the enrollment process.

PRV - 0084
Enrollment
Terminate the application process and notify the provider in writing if required information is not received within thirty (30) business days of not responding to a deficiency request.

PRV - 0085
Enrollment

Enter the status of each application (e.g., approved, denied, or pended) into the system on the day the determination is made.

PRV - 0090
Enrollment
Notify providers of the acceptance/rejection of the enrollment application in writing within five (5) business days of the provider enrollment decision.

PRV - 0092
Enrollment
Dis-enroll providers from all programs upon disenrollment from Medicaid as specified by the State, based on State-approved processes and procedures.

PRV - 0093
Enrollment
Assign a unique Texas Provider Identification (TPI) number to each individual or entity enrolled in any TMMIS program.

PRV - 0095
Enrollment
Enroll only group providers with associated performing providers unless otherwise directed by the State. A group Texas Provider Identifier (TPI)/National Provider Identifier (NPI) number cannot belong to an individual within the group or subsequently be assigned to an individual. Conversely, an individual provider TPI/NPI cannot be used as a group TPI/NPI.

PRV - 0096
Enrollment
Assign an Atypical Provider Identifier (API) to the provider when they are not eligible to obtain a National Provider Identifier (NPI) so that enrollment processing can proceed.

PRV - 0097
Enrollment
Update provider records and verify provider recertification requirements are met in accordance with State-defined timelines.

PRV - 0098
Enrollment

EXHIBIT B
Attachment 29
Provider (PRV)

Maintain and revise as directed by the State, all provider agreement templates to conform to all State-approved processes and procedures.

PRV - 0099
Enrollment
Make revisions to provider agreements/contracts within thirty (30) calendar days of the request by the State or a date agreed by the State.

PRV - 0100
Enrollment
Notify providers of any changes to agreements/contracts in a media approved by the State.

PRV - 0104
Enrollment
Manually update Provider Enrollment Portal (PEP) with Healthy Texas Women Program (HTW) Provider Enrollment certification information within thirty (30) business days of receiving paper certification by mail. This manual process is only applicable when a provider elects not to use either the online Provider Enrollment on the Portal (PEP) or the Online Provider Lookup (OPL) addendum.

PRV - 0105
Enrollment
Perform desk audits to verify provider Adopt, Implement, Upgrade (AIU) documentation for 100% of EHR participating providers based on State direction.

PRV - 0279
Enrollment
Terminate providers by Texas Provider Identifier (TPI) and suffixes associated with the National Provider Identifier (NPI)/Atypical Provider Identifier (API) as specifically directed by the State through the Medicaid Contract Administration Tracking System (MCATS) or the successor tracking system via a State Action Request and within the specified timeframe.

PRV - 0405
Enrollment
Verify monthly that enrolled providers, their associated business owners, and principals are not excluded or prohibited from participation in State and/or Federal Healthcare Programs as identified electronically on available federal databases, and State databases, including but not

limited to, State List of Excluded Individuals and Entities (LEIE) or as otherwise directed by the State. If matches are located, the information will be provided to designated State contact to request direction on terminating the provider, associated business owners, and/or principals.

PRV - 0406
Enrollment
Make available to providers, using State-approved processes and procedures, the ability to re-open closed enrollment applications.

PRV - 0411
Enrollment
Maintain a taxonomy crosswalk table with current and accurate data as approved by the State.

PRV - 0412
Enrollment
Conduct outreach to educate providers and conduct pre and post enrollment site visits for providers who were designated as a "moderate" or "high" categorical risk in accordance with federal regulations for provider screening.

PRV - 0413
Enrollment
Provide capability for State-approved users to verify prospective provider(s) and their business owner(s), at time of enrollment and re-enrollment, are not excluded or prohibited from participation in specified State and/or Federal Healthcare Programs as identified electronically on available federal databases, and State databases including but not limited to State List of Excluded Individuals and Entities (LEIE), State Do Not Enroll (DNE) and State Open Investigations (OIL) or as otherwise required by the State.

PRV - 0414
Enrollment
Provide response files to HHSC submitted provider files per State-approved timelines, one each for MCO LTSS and VDP areas for providers and their associated business owners on the status of providers in specified State and/or Federal Healthcare programs of available federal databases, State databases, including but not limited to State List of Excluded Individuals and Entities (LEIE), and or other sources provided by HHSC.

PRV - 0415
Enrollment
Maintain user manuals and training documentation consistent with software changes to State-approved provider data matching software (e.g., NocPlace S3 software) with content and in a media and format approved by the State.

PRV - 0416
Enrollment
Accurately identify providers that require pre-enrollment site visits as defined by the State.

PRV - 0003
General
Produce accurate and comprehensive educational materials, including but not limited to: provider workshops, trainings and publications according to State-approved content, format and schedules.

PRV - 0005
General
Assemble, under the direction of the State, ad hoc and permanent work groups of providers and State staff to review provider issues and proposed solutions.

PRV - 0008
General
Evaluate communication, training and publication revision needs for business process changes. Coordinate with and obtain approval from the State for proposed changes no less than ninety (90) calendar days of implementation.

PRV - 0009
General
Maintain a Web-based system for providers enrolled by CONTRACTOR that enables providers and clients to search and retrieve information and enables providers to update information as mutually agreed by the State.

PRV - 0012
General
Forward to the State, all provider correspondence pertaining to issues outside the purview of the CONTRACTOR, such as eligibility determination, Supplemental Nutrition Assistance Program

(SNAP) and Temporary Assistance for Needy Families (TANF) issues within three (3) business days of receipt.

PRV - 0013
General
Maintain and support an online, automated process that allows viewing by the State and CONTRACTOR staff of a replica of all correspondence received.

PRV - 0014
General
Support the ability to retrieve, display, and print all provider correspondence, including correspondence to and from field based provider relations specialists.

PRV - 0403
General
Provide a list of Healthy Texas Women Program certified providers with contact information to HHSC upon request.

PRV - 0404
General
Provide a quarterly updated list of enrolled Personal Care Services providers to include information as identified by the State. This list is due sixty (60) calendar days after the end of the quarter.

PRV - 0132
Maintenance
Use State-approved processes and procedures to accelerate enrollment of provider types as directed by the State.

PRV - 0136
Publications
Submit an annual work plan prior to September 1 for State approval that outlines a month by month review schedule of the Provider Procedure Manuals (PPMs).

PRV - 0137
Publications
Produce drafts and final versions of provider communications, and other relevant materials in a

manner that ensures consistency and accuracy across all publications, based on State-approved policy changes.

PRV - 0138
Publications
Develop for State approval and maintain a monthly process that updates the Provider Procedure Manuals (PPMs).

PRV - 0139
Publications
Provide a monthly summary to State staff that explains all updates, in detail, based on the State-approved publication schedule.

PRV - 0140
Publications
Maintain Provider Procedure Manuals (PPMs) in a format and media as approved and requested by the State.

PRV - 0141
Publications
Update and distribute the Provider Procedure Manuals (PPMs) according to the State-approved publication schedule, unless an exception is granted by the State.

PRV - 0142
Publications
Provider Procedure Manuals (PPMs) must contain detailed information about the State-approved program policies and procedures that will be in place based on the most recent updated version at the time of distribution.

PRV - 0143
Publications
Provide hard copies of program policies and procedures, upon request.

PRV - 0144
Publications
Provider Procedure Manuals must contain all changes requested and include other topics as

specified by the State.

PRV - 0147
Publications
Produce Provider Procedure Manuals (PPMs) and make available to providers, business partners and State staff in accordance with State-approved media, format, and distribution schedule.

PRV - 0148
Publications
Notify providers of any policy or benefit change in which provider benefits would be reduced or eliminated at least forty-five (45) calendar days prior to implementation of the policy or benefit change, or within State specified timeframes.

PRV - 0149
Publications
Develop provider notification and publication schedules for State review and approval and distribute electronically based on the State-approved publication schedules. Provide hard copies upon request from State.

PRV - 0150
Publications
Prepare and distribute to providers and HHSC up to ten (10) special bulletins per year, containing special or time sensitive information about program changes such as the Healthcare Common Procedure Coding System (HCPCS), as directed by the State.

PRV - 0151
Publications
Maintain an electronic, printable copy of provider publications for all provider communication, educational materials and other publications.

PRV - 0152
Publications
Support the ability to perform research, cross-referencing and indexing in the electronic formats of all provider publication materials.

PRV - 0153
Publications

Establish and maintain a document revision trail that is displayed on each form letter and template.

PRV - 0154
Publications
Archive all versions of provider publications and make available to the State upon request.

PRV - 0174
Recruitment
Propose for State approval an Annual Provider Recruitment and Retention Plan that describes goals, objectives and evidence based activities for maximizing provider enrollment, recruitment, and retention, and promotes provider satisfaction for all State-approved programs.

PRV - 0175
Recruitment
Submit an Annual Provider Recruitment and Retention Plan to HHSC in accordance with State-approved content, format and schedule.

PRV - 0176
Recruitment
Include in Annual Provider Recruitment and Retention Plan, measurable goals to evaluate recruitment and retention efforts.

PRV - 0182
Recruitment
Execute the State-approved Annual Provider Recruitment and Retention Plan as defined by the State.

PRV - 0183
Recruitment
Fulfill 100% of all program staff requests to participate in expert forums within thirty (30) calendar days of the request.

PRV - 0191
Recruitment
Identify and report monthly all enrolled providers by program, who have been inactivated and the reasons for non-participation. Reports must be submitted to HHSC by the 20th calendar day

of the following month, with content in a media and format approved by the State.

PRV - 0192
Recruitment
Update and maintain provider participation maps file layout.

PRV - 0193
Recruitment
Develop and submit provider maps reports with content and in a format and frequency specified by the State.

PRV - 0194
Recruitment
Conduct recruitment efforts for all enrolled Vendor Drug Program pharmacies that are eligible to provide durable medical equipment to become Medicaid-enrolled and CSHCN Services Program-enrolled.

PRV - 0196
Recruitment
Provide outreach to provider associations per established provider relations processes.

PRV - 0399
Recruitment
Conduct outbound calls to locate Healthy Texas Women Program providers and provide client outreach services using appropriately skilled staff when further client assistance is required.

PRV - 0400
Recruitment
Locate Healthy Texas Women Program (HTW) providers for a client requesting additional assistance in locating an HTW provider accepting HTW clients within the client's service area within three (3) business days of the request for client assistance.

PRV - 0401
Recruitment
Notify HHSC and client after three (3) business days of the status of attempting to locate a HTW provider for a client requesting additional assistance.

PRV - 0402
Recruitment
Conduct outbound telephone calls and office visits for HTW provider recruitment and retention as directed by the State.

PRV - 0198
Reimbursement
Maintain the provider master file and tables, and rate and reimbursement data in a date-sensitive manner to ensure that all claims processed initially and adjustments applied later use the proper rate(s) applicable for the date of service.

PRV - 0203
Reimbursement
Provide HHSC with any and all data specified by HHSC as necessary for the Medicaid Disproportionate Share Hospital (DSH) program. The DSH annual reports will be delivered on or before the last business day prior to April 16th each contract year. Provide access to the Medicaid DSH data through an online ad hoc reporting tool. Produce predefined reports each year to assist HHSC Finance Division with verification and quality assurance tasks associated with calculating the DSH payments. The detailed data used to calculate DSH payments will be generated annually and delivered to HHSC on or before the last business day prior to April 16th. The source data used to create the reports will be available to the HHSC Finance Division through the specialized online ad hoc reporting tool universe for institutional reimbursement.

PRV - 0209
Reimbursement
Provide electronic access to and reporting capability of the TMMIS Operational Data Store for State specified staff. Reporting capabilities include State specified predetermined reports, ad hoc reports, and CONTRACTOR generated reports as specified by the State.

PRV - 0215
Reimbursement
Forward improperly completed or incomplete DSH appeal claims received from providers to HHSC for return to the providers or other resolution within State-approved timeframes.

PRV - 0216
Reimbursement
Send DSH appeal claims and encounters data detail reports to providers in an appropriate format

at HHSC's direction.

PRV - 0217
Reimbursement
Send appeal templates for claims and encounters with instructions in HHSC approved format to providers upon receipt of a request for DSH data at the direction of HHSC.

PRV - 0218
Reimbursement
Answer general questions from providers, prior to receipt of provider appeals for DSH claims and encounters.

PRV - 0219
Reimbursement
Provide support to providers for the use of a robust secure FTP for the purpose of receiving provider appeals for DSH claims and encounters and sending appeal information back to the providers.

PRV - 0220
Reimbursement
Support the separate electronic mailbox for the DSH appeals process for DSH claims and encounters.

PRV - 0221
Reimbursement
Include a standard message in the email signature block to remind providers appealing DSH claims and encounters of the secure email transmission protocols, and of the secure FTP file exchange process.

PRV - 0222
Reimbursement
Assign specified directories on secure FTP for the DSH provider appeals process.

PRV - 0223
Reimbursement
Assign user IDs to the secure FTP solution used to exchange data and interface files to State-approved business partners as requested by the providers or their representatives for the DSH

provider appeals process (claims and encounters).

PRV - 0224
Reimbursement
Electronically receive DSH provider appeal claims and encounters appeals.

PRV - 0225
Reimbursement
Send DSH provider appeal claims and encounters appeals received in a non-electronic format to HHSC.

PRV - 0226
Reimbursement
Retrieve DSH provider appeal claims and encounters appeals from the TxMedCentral secure FTP site.

PRV - 0227
Reimbursement
Retrieve DSH provider communications from an electronic mailbox for DSH provider appeal claims and encounters appeals.

PRV - 0228
Reimbursement
Validate DSH provider appeal claims and encounters appeals.

PRV - 0229
Reimbursement
Determine if an electronically received DSH provider appeal claim is to be added or deleted from the DSH database.

PRV - 0231
Reimbursement
Send DSH appeal claims determination emails to providers on in a content, media and format approved by HHSC.

PRV - 0232
Reimbursement
Archive final versions of DSH appeal claim and encounters appeal templates from providers in a State-approved accessible electronic format for a period specified by the State.

PRV - 0233
Reimbursement
Archive DSH appeal claims and encounter appeal determination to providers in a content, media and format approved by the State.

PRV - 0234
Reimbursement
Maintain provider payment processes including electronic funds transfer (EFT) payments to providers and designated entities.

PRV - 0235
Reimbursement
Assist HHSC in the performance of the DSH claims or encounters appeals process on an annual Federal Fiscal Year (FFY) basis.

PRV - 0236
Reimbursement
Document the determination of DSH provider claims appeals and encounter appeals on the appeals template for completeness and TAC rules compliance.

PRV - 0237
Reimbursement
CONTRACTOR will on an annual basis produce the DSH Encounter Reports (INRRE401B, INRRE402B, INRRE403B, and INRRE404B). Reports will be delivered on or before the last business day prior to April 16th each Contract year.

PRV - 0238
Reimbursement
Make available for on demand purposes in Business Objects the annual DSH Encounter Reports (INRRE401B, INRRE402B, INRRE403B, and INRRE404B). The content of the reports must be as approved by the State, be accurate and in the media and format approved by the State.

PRV - 0408
Reimbursement
Make payments to enrolled providers per State-approved processes and procedures.

PRV - 0409
Reimbursement
Add vendor payment holds within one (1) business hour for providers that the Office of Inspector General (OIG) identifies as having a credible allegation of fraud or program violation.

PRV - 0410
Reimbursement
Accurately add vendor payment holds for providers that the Office of Inspector General (OIG) identifies as having a credible allegation of fraud or program violation.

PRV - 0239
Reporting
Annually update State-approved processes and procedures for provider cost report processing in a format, content and media available to and approved by the State.

PRV - 0241
Reporting
Produce and deliver for State approval the annual work plan related to cost report activities no later than thirty (30) calendar days after the start of the State Fiscal Year.

PRV - 0242
Reporting
Submit updates to the State-approved annual work plan related to cost report activities no later than thirty (30) calendar days after identification of new requirements.

PRV - 0243
Reporting
Perform the required annual review and produce the provider's tentative cost settlement report within six (6) months of receipt of an acceptable cost report for hospitals. Perform the required review and produce the provider's final cost settlement report within six (6) months of receipt of the Medicare audited or Settled-without-audit cost report, the prior year's Medicare audited or Settled-without-audit cost report, and the hospital based physician's rational form for hospitals. Determine the Medicaid inpatient and outpatient ratios of cost to charges used in the inpatient

and outpatient services reimbursement methodologies. Conduct annual onsite reviews for children's hospitals.

PRV - 0244
Reporting
Perform the appropriate cost report process activities according to written State-approved policies and procedures.

PRV - 0245
Reporting
Perform provider's cost settlement review for Federally Qualified Health Care Centers (FQHCs) and Rural Health Care Centers (RHCs) upon State request and produce the provider's cost settlement report within State defined timelines.

PRV - 0246
Reporting
Determine the Medicaid facility specific encounter rate per visit for FQHCs and RHCs in accordance with State-approved processes and procedures.

PRV - 0247
Reporting
Utilize Medicaid FQHCs and RHCs encounter rate cost settled rates for Children with Special Health Care Needs (CSHCN) Services Program enrolled FQHCs and RHCs.

PRV - 0248
Reporting
Use audit information provided by or purchased from the Medicare intermediary to the fullest extent possible to prevent or minimize duplication of effort and cost to the program.

PRV - 0249
Reporting
Require hospitals, FQHCs and RHCs to submit in a timely basis the applicable cost report or State-approved alternative.

PRV - 0250
Reporting
Verify the allowable cost during required hospital cost reviews using the applicable Texas

Administrative Code (TAC) reimbursement methodology rules.

PRV - 0251
Reporting
Follow State-approved processes and procedures for handling provider cost reports.

PRV - 0252
Reporting
Maintain a database(s) to be used as the comprehensive provider cost report process tracking tool with parameters to be approved by the State.

PRV - 0254
Reporting
Retain all electronic versions of hospital cost reports associated documentation in accordance with State defined retention guidelines.

PRV - 0255
Support
Establish, maintain and document methods to edit and verify all data elements for completeness and consistency before the Provider Master File and tables are updated.

PRV - 0256
Support
Provide flexibility to quickly add or update data fields and elements to the Provider Master File and Tables, as directed by the State.

PRV - 0258
Support
Maintain all provider enrollment documentation in an electronic file, online and via document imaging for hardcopy materials.

PRV - 0261
Support
Maintain current provider data in the Provider Master File and tables.

PRV - 0262
Support
Ensure all updates to the Provider Master File and tables meet State-approved processes and procedures.

PRV - 0264
Support
Provide the ability to distinguish Provider Master File changes for active and inactive providers by program.

PRV - 0267
Support
Maintain automated and complete electronic audit trail(s) of all changes made in the Provider Master File and tables, identifying the date-timestamp and user.

PRV - 0269
Support
Provide online access to State-approved staff to the audit trail information for Provider Master File and tables.

PRV - 0270
Support
Correct all erroneous data in the Provider Master File or tables resulting from any CONTRACTOR action, and notify HHSC and all appropriate State-approved business partners within twenty-four (24) hours of such discovery.

PRV - 0271
Support
Identify providers, on a monthly basis, who need to be assigned an inactive or terminated status, based on State-approved rules and guidelines.

PRV - 0272
Support
Send program termination notices to providers within five (5) business days of the termination action. Termination notices must be in a media and content approved by the State.

PRV - 0274
Support
Maintain the ability to reactivate providers, based on State-approved guidelines.

PRV - 0275
Support
Provide the ability to place providers on payment hold, by National Provider Identifier (NPI)/Atypical Provider Identifier (API), or Texas Provider Identifier (TPI) and suffix, or the seven (7) digit TPI core number.

PRV - 0276
Support
Maintain an automated process to update the provider master data files and tables with monthly feeds from various board files to include but not limited to:

a) Texas Medical Board;

b) Texas Nursing Board; and

c) Texas Dental Board, etc.

PRV - 0278
Support
Apply an indicator to the provider record to suspend payments when notification is received regarding an inactive or invalid licensure or as directed by the State.

PRV - 0280
Support
Provide online access to State staff and State-approved business partners to all information for each enrolled provider.

PRV - 0281
Support
Provide an extract of the Provider Master File and tables to HHSC and State-approved business partners within timeframes, with content and in a media and format approved by the State.

PRV - 0282
Support
Produce a daily electronic report that contains an audit trail of all additions, changes and

deletions in the Provider Master File and tables, and make available to HHSC upon request.

PRV - 0284
Support
Capture provider data that indicates the reasons why providers dis-enroll from the program(s).

PRV - 0286
Support
Provide a quarterly report on provider disenrollment analysis, by program and provider type, to HHSC within timeframes and with content and in a media and format with a timeframe approved by the State.

PRV - 0292
Support
Produce a weekly vendor hold report which includes partial holds and vendor holds, with content, and in media, and format with a timeframe approved by the State.

PRV - 0295
Support
Maintain the ability to retrieve and restore online access of archived provider records within three (3) business days of request or as directed by the State.

PRV - 0296
Support
Furnish program specific Provider Transaction Error Reports identifying the error, type of error and date of error identification.

PRV - 0299
Support
Maintain a process to communicate with National Plan and Provider Enumeration System (NPPES), to gather and validate information about providers and their National Provider Identifiers (NPIs).

PRV - 0300
Support
Enumerate and disseminate atypical provider identifiers for Acute Care providers that are not eligible for an National Provider Identifier (NPI) via National Plan and Provider Enumeration

System (NPPES), but do qualify to participate in Texas state programs.

PRV - 0301
Support
Provide complete and accurate information to resolve all provider inquiries to the extent possible. Respond to 95% of provider inquiries within fifteen (15) calendar days of receipt of the inquiry, and respond to the remaining 5% of provider inquiries within thirty (30) calendar days of receipt.

PRV - 0303
Support
Review the most current Office of Inspector General (OIG) open case list prior to responding to any provider inquiries; follow State-approved procedures for inquiry resolution.

PRV - 0304
Support
Maintain up-to-date information sourced from providers on the Online Provider Look-up (OPL) system about which providers of health care services in each geographic area are accepting new patients as specifically defined by the programs.

PRV - 0305
Support
Contact all providers annually to verify current provider demographic information; changes must be updated via State-approved processes.

PRV - 0306
Support
Provide an email address for providers to send comments, complaints, and inquiries. No automatic email response should direct the inquirer to only contact any CONTRACTOR area by telephone. CONTRACTOR must ensure responses to all comments, complaints, and inquiries are responded to within two (2) business days from receipt of the email. In those cases where final resolution is not possible within two (2) business days, a uniform tracking number must follow the case. CONTRACTOR must also indicate to the inquirer when a response will be received and the medium in which to expect the response if other than email.

PRV - 0307
Support

Provide the Medicaid Eligibility Health Information Services (MEHIS) Contractor with access to the Master Provider File and the Excluded Provider File.

PRV - 0309
Support
Log all Electronic Health Record (EHR) Incentive Program inquiries within a State-approved media file on a State-approved secure FTP site for each type of inquiry following the completion of the response.

PRV - 0310
Training, Education and Materials
Develop for State approval an Annual Provider Training Plan with content and in a media and format approved by the State.

PRV - 0312
Training, Education and Materials
Meet with State staff during the initial planning phase for development of annual provider workshop materials (i.e., Workbooks, guides, speaker notes, etc.).

PRV - 0313
Training, Education and Materials
Collaborate with State staff on strategic focus and goals to be met for provider workshops.

PRV - 0314
Training, Education and Materials
Develop training and educational materials based on the outcomes of collaborative discussions for provider workshops.

PRV - 0315
Training, Education and Materials
Update and maintain training materials for provider workshops and training sessions for Medicaid and State programs.

PRV - 0321
Training, Education and Materials
Develop training materials for State approval for all State programs, including provider training

materials covering their usage of the TMMIS.

PRV - 0322
Training, Education and Materials
Upon State request print and distribute State-approved provider training materials as directed by the State.

PRV - 0323
Training, Education and Materials
Coordinate with HHSC during the development of provider materials to ensure materials are produced with content, media and format approved by the State.

PRV - 0324
Training, Education and Materials
Schedule and conduct provider workshops and training sessions in accordance with the State-approved Annual Provider Training Plan.

PRV - 0325
Training, Education and Materials
Provider workshops and training sessions must be conducted in sufficient numbers, as approved by the State, to adequately train all provider types, including but not limited to targeted provider types.

PRV - 0326
Training, Education and Materials
Conduct provider training and workshops in sufficient numbers and in rotating locations as directed by the State.

PRV - 0328
Training, Education and Materials
Conduct in-service training and answer questions concerning all State programs at the request of the provider, the provider's staff or the provider's billing agent.

PRV - 0333
Training, Education and Materials
Track and monitor all issues that are escalated to ensure that responses are communicated promptly and accurately to providers, provider's staff, provider's billing agent, and third party

vendors.

PRV - 0334
Training, Education and Materials
Provide and distribute to attendees of specified workshops (to include but not limited to THSteps computer based training (CBT) for Medical and Dental) all applicable materials as approved by the State. CONTRACTOR will distribute materials provided by the State at the workshops.

PRV - 0335
Training, Education and Materials
Distribute to attendees a State-approved training evaluation form, with the content and format approved by the State, to evaluate training for all training sessions.

PRV - 0336
Training, Education and Materials
Distribute training evaluation forms to all participants to evaluate training and solicit provider/participant feedback.

PRV - 0337
Training, Education and Materials
Provide copies of attendee evaluations to the State upon request.

PRV - 0338
Training, Education and Materials
Analyze provider/participant training evaluation feedback and provide evidence based recommendations for improving training.

PRV - 0339
Training, Education and Materials
Communicate with the provider within three (3) business days of training or initial provider contact and answer any questions or resolve issues over the phone.

PRV - 0340
Training, Education and Materials
Schedule a mutually agreed upon training session/visit with State-approved staff as directed by the State.

PRV - 0341
Training, Education and Materials
Submit a quarterly summary report to HHSC about training sessions including the number and type of participants. The report is due by the 60th calendar day following the end of the state fiscal quarter.

PRV - 0342
Training, Education and Materials
Assist providers and their representatives in the use of all electronic and web supported tools and applications.

PRV - 0343
Training, Education and Materials
Develop for State approval an Annual Provider Training Plan, including plans to maximize the use of electronic and web supported tools and applications by providers, providers' staff and provider's billing agent, and submit the plan to HHSC for approval on or before the last business day prior to April 16th each Contract year.

PRV - 0344
Training, Education and Materials
Respond to request for provider training needs within three (3) business days of the provider initiated contact or as directed by the State.

PRV - 0345
Training, Education and Materials
Develop for State approval communications and educational activities to inform health care providers about the availability of Case Management for children and pregnant women including how to make referrals, and where to report problems with referrals. Implement the communications and educational activities as directed by the State.

PRV - 0347
Training, Education and Materials
Upon provider's request, CONTRACTOR's field consultants will provide onsite support to providers, providers' staff, and/or providers' billing agents, and contact providers within ten (10) business days to schedule a mutually agreeable visit following the provider's request, unless otherwise directed by the State.

PRV - 0348
Training, Education and Materials
Inform provider groups and HHSC about group training sessions at least four (4) weeks prior to presentation or at other intervals specified by the State.

PRV - 0349
Training, Education and Materials
Training sessions and training materials will be provided at no cost to attendees unless otherwise authorized in writing by the State.

PRV - 0351
Training, Education and Materials
Provide a link from the CONTRACTOR website to the HHSC Online Provider Education (OPE) modules.

PRV - 0352
Training, Education and Materials
Publicize the availability of free continuing education (CE) credits through DSHS online modules in appropriate provider training and education materials and workshops (to include but not limited to THSteps computer based training (CBT) for Medical and Dental).

PRV - 0353
Training, Education and Materials
Maintain accurate, current, and complete provider education materials, including provider procedure manuals, banner messages, web postings and training materials for all programs under the Contract.

PRV - 0354
Training, Education and Materials
Post all State-approved training and educational materials on the CONTRACTOR's website.

PRV - 0356
Training, Education and Materials
Obtain State approval for all provider education materials prior to publication or presentation.

PRV - 0358
Training, Education and Materials

EXHIBIT B
Attachment 29
Provider (PRV)

Maintain an automated communications tracking and retrieval system to memorialize all contacts and correspondence with providers, provider's staff and provider's billing agent including type of contact, reason for contact, and outcome.

PRV - 0360
Training, Education and Materials
Deliver a monthly summary report on provider contacts and correspondence with content and in a timeframe, media and format approved by the State.

PRV - 0362
Training, Education and Materials
Publish an annual provider notification using web article and banner message to inform providers of the posting of Potentially Preventable Readmission analysis results to the HHSC secure portal on an annual basis or other time period as defined by HHSC. HHSC will contribute content specifics and approval for these communications using HHSC provider publication approval procedures.

PRV - 0364
Training, Education and Materials
Maintain State-approved Electronic Health Record (EHR) Incentive Program desk audit procedures.

PRV - 0365
Training, Education and Materials
Develop for State approval and distribute communications materials including FAQs, banner messages, workshop materials, provider procedure manuals, and website information with content and format approved by the State.

PRV - 0366
Training, Education and Materials
Deliver communication regarding the Electronic Health Record (EHR) Incentive Program via FAQs and banner messages in a content, format, and frequency approved by the State.

PRV - 0367
Training, Education and Materials
Develop required updates to Frequently Asked Questions (FAQs) and other Electronic Health

Record (EHR) provider materials as approved by the State.

PRV - 0368
Training, Education and Materials
Deliver up to five (5) MI360 product demonstrations to HHSC and their stakeholders (not including providers) for the Electronic Health Record (EHR) Incentive Program and provide educational support related to the demonstrations as defined by the State.

PRV - 0369
Training, Education and Materials
Review and update course/training materials as needed to include new programs, e.g., Youth Empowerment Services (YES) Waiver benefits.

PRV - 0370
Training, Education and Materials
Update, as needed, the Medicaid Basics I and II live provider workshop materials and Computer Based Trainings (CBTs) for additional impacts due to the implementation of new programs, e.g. Youth Empowerment Services (YES) Waiver.

PRV - 0371
Training, Education and Materials
Notify providers via web postings and banner messages of the changes implemented for new programs, *e.g.*, Youth Empowerment Services (YES) Waiver program.

PRV - 0373
Training, Education and Materials
Maintain the link to the taped Potentially Preventable Complications (PPC) webinars on the HHSC website for ongoing provider access.

PRV - 0374
Training, Education and Materials
Disseminate annually, or other time period as defined by HHSC, Potentially Preventable Complications (PPC) results to hospital providers through a secure portal.

PRV - 0375
Training, Education and Materials
Publish an annual provider notification to inform providers of the posting Potentially Preventable

Complications (PPC) reports analysis results to a secure portal on an annual basis or other time period as defined by the State within forty-five (45) calendar days of the start of the State Fiscal Year.

PRV - 0376
Training, Education and Materials
Send an annual letter to providers to notify them of their specific Pay for Quality adjustment rate. HHSC will provide content, timing, and approval for the letter.

PRV - 0394
Training, Education and Materials
Update and maintain the CONTRACTOR website with Healthy Texas Women Program (HTW) specific information as approved by the State.

EXHIBIT B
Attachment 30
Reference Data Maintenance (RDM)

RDM - 0002
General
Analyze and recommend changes to reference file tables to support efficient claims processing and as directed by the State.

RDM - 0003
General
Receive State approval of all changes to reference file tables within timelines as directed by the State.

RDM - 0007
General
Maintain the State-approved quality control process and standard to ensure the integrity of the reference files (e.g., claims price correctly, edits and audits post according to specifications, etc.) in the TMMIS.

RDM - 0008
General
Maintain an online audit trail to view the most recent changes made to reference files to include the person making the change, date and time of the change, and project ID.

RDM - 0009
General
Maintain an audit trail to identify all changes made to reference files and make available to the State upon request.

RDM - 0011
General
Notify the State within one (1) business day of identification of any discrepancies found with reference table updates.

RDM - 0014
General
Develop for State approval timelines for reference file update projects that delineates planned activities as directed by the State.

RDM - 0022
General
Coordinate and schedule meeting(s) monthly or on a frequency defined by the State to discuss pricing and fee-for-service reimbursement recommendations.

RDM - 0023
General
Implement all State-approved reference file changes in the system within sixty (60) calendar days of request or within State-approved timelines to ensure that providers are paid correctly.

RDM - 0024
General
Develop for State approval new, or revise existing pricing methodologies and fees, and/or specific pricing criteria, and calculate the estimated annual fiscal impact of proposed fee adjustments in a format, content, media and timeframe approved by the State.

RDM - 0025
General
Maintain information within the reference tables in accordance with State-approved policies, processes and procedures.

RDM - 0029
General
Manually update Diagnosis Review Groupings (DRG) codes, including base rates, capital, medical education, and weights, on a timeline specified by the State.

RDM - 0037
General
Update the taxonomy crosswalk table within a timeline approved by the State.

RDM - 0042
General
Coordinate any required changes to adjudication guidelines for any newly created or updated edits/audits within agreed upon timelines for State review and approval.

RDM - 0047
General

EXHIBIT B
Attachment 30
Reference Data Maintenance (RDM)

Perform quality verification to the Static fee schedules as directed by the State on procedure code fee information by comparing data to active reference files.

RDM - 0048
General
Perform quality verification to the online fee lookup portal as directed by the State on procedure code fee information by comparing data to active reference files.

RDM - 0055
General
Support any new or changes to the National Correct Coding Initiative (NCCI) edits as agreed upon with the State.

RDM - 0056
General
Provide a monthly performance report detailing the claims impact of NCCI edits to include CMS required components, including but not limited to the following:

a) An executive summary;

b) Status report of cumulative and monthly savings;

c) Financial overview savings;

d) Provider impact summary;

e) Provider inquiry statistics; and

f) Recommendations for improvement.

Reports must be submitted to the State with content in a media, format and timeframe approved by the State.

RDM - 0057
General
Produce and deliver for State approval the annual work plan related to Medicaid Calendar fee review activities no later than thirty (30) calendar days after the start of the State Fiscal Year. Provide the CSHCN fee review calendar within thirty (30) calendar days after approval of the Medicaid annual work plan.

EXHIBIT B
Attachment 30
Reference Data Maintenance (RDM)

RDM - 0058
General
Create annually, on or before the last business day in April, the database that is the basis for calculating the rates used in the Medicaid inpatient hospital DRG based reimbursement system (the "Blue Ribbon File").

RDM - 0059
General
Publish all fees for professional and outpatient facility services in fee schedules accessible to providers on a HHSC defined repository (*i.e.*, look up fee schedule).

RDM - 0060
General
Update the static fee schedules quarterly by the 15th calendar day of the federal fiscal quarter.

RDM - 0061
General
Maintain "search" capabilities to the fee schedule look up function so that providers are able to easily determine if a procedure code is a benefit or not, as well as the applicable fee.

RDM - 0062
General
Respond to provider and State inquiries relating to procedure code fee information displayed on the static fee schedules and on the online fee lookup (OFL) using procedures for handling emails, phone calls, and MCATS as defined in the P&Ps depending on the source of the inquiry.

RDM - 0063
General
Update institutional reimbursement rates and data whenever the provider-specific cost audit and settlement indicates the need for an adjustment.

RDM - 0064
General
Update provider master file and reference file tables, for rate and reimbursement data as directed by the State.

EXHIBIT B
Attachment 30
Reference Data Maintenance (RDM)

RDM - 0065
General
Research and analyze impacts of coding updates (e.g., HCPCS, ICD, DRG, NCCI) within scheduled timeframes approved by the State.

RDM - 0066
General
Establish, maintain, and facilitate workgroups to discuss and make recommendations for coding updates (e.g., HCPCS, ICD, DRG, NCCI) with State staff and State-approved business partners.

RDM - 0067
General
Perform NPI/TPI crosswalks and validations for providers identified to receive Potentially Preventable Events (PPE) reductions.

RDM - 0068
General
Maintain the Taxonomy to Provider Type/Specialty crosswalk, and all related documentation. Upon approval from the State, release Taxonomy crosswalk updates.

RDM - 0069
General
Participate in State activities around policy changes to ensure reference file tables are up to date and required reference file changes are clearly and correctly identified.

RDM - 0070
General
Provide the State with all the reference data elements for scheduled comprehensive or focused policy reviews within fifteen (15) business days of request or as directed by the State.

EXHIBIT B
Attachment 31
Reporting – Ongoing and Ad Hoc (AHR)

AHR - 0002
Maintenance
Maintain at least a rolling one-hundred twenty (120) months of claims and encounter history and supporting data for use by the Ad Hoc Query Platform (AHQP) function.

AHR - 0003
Maintenance
Maintain a process to modify the schema for the AHQP, to include new data elements as directed by the State.

AHR - 0004
Maintenance
Maintain a process to modify import/export functions to transfer new data from the TMMIS production database to the AHQP database, as directed by the State.

AHR - 0005
Maintenance
Update ad hoc database tables at minimum on a weekly basis, and as needed, including AHQP database client eligibility tables, and the financial and claims tables.

AHR - 0006
Maintenance
Maintain an online data report repository that identifies the version history of each report.

AHR - 0007
Maintenance
Maintain an online descriptive index of each online report identifying the business owner and include a report overview that outlines the intended use of the report. Provide the report to the state on an annual basis, or as approved directed by the State.

AHR - 0008
Maintenance
Maintain an audit trail of changes of data definitions and each report design change in a user-friendly format and language approved by the State.

EXHIBIT B
Attachment 31
Reporting – Ongoing and Ad Hoc (AHR)

AHR - 0010
Maintenance
Maintain the capability to purge reports from the online data report repository and index as directed by the State.

AHR - 0011
Maintenance
Provide access to ad hoc query and reporting capabilities to State-approved users.

AHR - 0012
Maintenance
Maintain AHQP software, hardware, and database architecture as required to support State and CONTRACTOR initiated ad hoc queries.

AHR - 0019
Maintenance
Maintain and update the State-approved manual that instructs users on table AHQP structures, including data elements, definitions, and instruction on how to create program specific queries. Update the manual to cover changes in data, processes, and procedures when identified. Maintain the ability to produce paper versions of the State-approved user manual at the State's request.

AHR - 0015
Production
Establish and facilitate quarterly meetings (or as requested by the State) for the State's ad hoc query business users covering changes in data structure and improvements in functionality. Discuss current issues in performing queries and data extracts and identify possible solutions.

AHR - 0020
Production
Respond to requests for technical assistance on functionality and using the ad hoc query tool within one (1) business day of receipt of request from the State, or State-approved business partners, and within two (2) hours of receipt, in situations defined as urgent by the State.

AHR - 0024
Production
Coordinate with requesters to identify parameters and expected results for ad hoc query and extract requests. Provide end user appropriate documentation to the requester for each ad hoc

query and extract within agreed upon timeframe.

AHR - 0026
Production
Upon request, produce and deliver accurate ad hoc queries, extract results, and templates within specified timeframes, with content, and in a media and format approved by the State.

AHR - 0045
Production
Maintain response files for thirty (30) calendar days before archiving for DSHS detailing errors associated with Health Level 7 (HL7) message transformation / validation.

AHR - 0055
Reporting
Document and advise the State and requester when it is determined that there is the potential of a missed timeframe for an ad hoc query.

AHR - 0056
Reporting
Notify the State within one (1) business day of identification of the missed production timeframe to receive direction on resolution for an ad hoc query or data extract that was missed.

AHR - 0059
Reporting
Analyze and provide a report on the performance of the AHQP on a quarterly basis at minimum with content, and in a media and format approved by the State. Include information such as type of queries run, concurrent users, query response time, input/output speed, and the efficiency of the operating system and support software and provide recommendations for improvements (e.g., a query should become a production report). Reports are due on the 60th calendar day after the end of the quarter.

AHR - 0062
Reporting
Provide designated Data Analyst(s) to assist the State with the development and analysis of data requests.

EXHIBIT B
Attachment 31
Reporting – Ongoing and Ad Hoc (AHR)

AHR - 0063

Reporting

Provide a separate copy of the most recent three (3) years of claims and encounter history for use by the Ad Hoc Query Platform to improve query performance.

EXHIBIT B
Attachment 32
Surveillance/Utilization Review (SUR)

SUR - 0003
General
Maintain pre-payment review adjudication criteria as approved by State.

SUR - 0004
General
Surveillance and Utilization Review (SUR) operations must include Texas licensed registered nurses and have access to health professionals (i.e., physical, occupational, audiologist/speech therapists) who reside in Texas, with available licensed physician and dentist oversight and support to perform all required SUR analysis functions.

SUR - 0005
General
Meet monthly with State staff to discuss identified providers who may require education, sanctions, or investigation by the State.

SUR - 0006
General
Obtain State approval and direction for all provider review activity.

SUR - 0007
General
Conduct medical/dental record review to review documentation for compliance with program policy and Medical/Dental Policy, as directed by the State.

SUR - 0009
General
Perform administrative and infrastructure tasks and activities required to sustain daily operations in support of the SUR function per State-approved processes and procedures.

SUR - 0023
General
Obtain State approval to hire State designated licensed professionals (with the exception of registered nurses) to perform SURs related work prior to hiring.

SUR - 0024
General
Notify the State via email on any SUR case actions and case status updates according to State-approved processes and procedures.

SUR - 0025
General
Report to the State suggested changes to medical policy based on SUR findings upon discovery of the potential issue or improvement.

SUR - 0028
General
Provide the End of State Fiscal year report of SUR activities no later than thirty (30) calendar days after the end of the State Fiscal year with content and in a media and format approved by the State.

SUR - 0011
Litigation Support
Provide the capability to place providers on either 100% review for all claims submitted or partial review for submitted claims involving specific procedure(s), as directed by the State.

SUR - 0012
Litigation Support
Compile, maintain, and present evidence and provide testimony at trials, hearings and other judicial or administrative proceedings to assist the State and Office of Attorney General. Evidence may include, but is not limited to, claims, copies of canceled checks, remittance advices, itemized statements, charge tickets, provider training documents, correspondence, policy and procedure manuals, and other documents as may be required.

SUR - 0013
Litigation Support
Provide all document retrieval, copying, preparation, and travel costs for CONTRACTOR staff called as witnesses to the State, at no additional cost to the State. The number of hearings and trials varies from year to year.

SUR - 0014
Publications

EXHIBIT B
Attachment 32
Surveillance/Utilization Review (SUR)

Prepare educational materials for the program bulletins to providers, promoting appropriate clinical practices and accurate billing based on SUR findings as directed by the State.

SUR - 0015
Recoupments and Adjustments
Identify opportunities from SUR reviews for recouping inappropriate payments in accordance with State-approved Medicaid program regulations, processes and procedures.

SUR - 0018
Recoupments and Adjustments
Notify the State of any provider appeal request within one (1) business day of SUR receipt of the request.

SUR - 0022
Recoupments and Adjustments
Establish accounts receivable for all Surveillance Utilization Review System recoveries, in compliance with all State-approved processes, procedures, and Quality Assurance processes.

SUR - 0026
Recoupments and Adjustments
Provide written notice to providers of SUR review results within fourteen (14) calendar days of final State approval of the medical record review with content and in a media and format approved by the State.

SUR - 0020
Training, Education and Materials
Provide written notice, telephonic communication, or face-to-face meetings with providers for educational interventions based on SUR findings as directed and approved by the State.

SUR - 0027
Training, Education and Materials
Provide a monthly report on claim by claim recoupment status no later than three (3) business days before the end of the current month with content and in a media and format approved by the State.

EXHIBIT B
Attachment 33
Systems (SYS)

SYS - 0016
Disaster Recovery
Prepare and submit for State approval a comprehensive Disaster Recovery Plan and submit to HHSC for approval on an annual basis. The Disaster Recovery Plan must adhere to State-approved processes and procedures and at a minimum must include: a) Checkpoint/restart capabilities; b) Retention and storage of backup files and software; c) Hardware backup for the servers; d) Hardware backup for data entry equipment; e) Network backup for telecommunications; f) Telephone communications lines to the disaster backup site; g) Recovery prioritization list (hardware and software applications); and h) Telecommunication Voice Switch.

SYS - 0017
Disaster Recovery
In accordance with the mutually agreed Business Continuity and Disaster Recovery Plan(s), provide backup processing capability at a remote site from CONTRACTOR's primary site such that normal TMMIS processing can continue in the event of a disaster or major hardware problem at the primary site. All operations at the remote backup site will function in accordance with the mutually agreed Business Continuity and Disaster Recovery Plan(s).

SYS - 0018
Disaster Recovery
Achieve a complete recovery of affected systems from a disaster or other major problem within the timeframes specified for each application.

SYS - 0019
Disaster Recovery
Coordinate with and demonstrate to HHSC CONTRACTOR's and State requested subcontractors' disaster recovery capabilities annually as directed by the State. Include recovery of any new functionality implemented during the previous year unless otherwise directed by the State.

SYS - 0021
Disaster Recovery
Upon HHSC declaration of a disaster, resume normal operational business functions at the earliest possible time, not to exceed five (5) calendar days or as otherwise specified in the State-approved Disaster Recovery Plan.

SYS - 0023
Disaster Recovery
Plan and coordinate disaster simulation and recovery activities with State-approved trading partners.

SYS - 0024
Disaster Recovery
Coordinate with and demonstrate to HHSC the Business Continuity and Contingency Plan (BCCP) every calendar year in conjunction with the annual disaster recovery demonstration.

SYS - 0237
Documentation
Identify and track all system change requests through the State-approved change management process. Assign each request a unique number and include the CONTRACTOR business owner on all State or CONTRACTOR initiated projects.

SYS - 0004
General
Maintain coordination methods and processes for system changes that impact all internal business areas as well as other State-approved business partners, including participation for documentation walk-through(s), documentation updates and all system testing activities.

SYS - 0005
General
Maintain methods and processes for system changes that impact providers and vendors who submit electronic transactions, including documentation updates and all system testing activities.

SYS - 0006
General
Work with HHSC and the other State-approved business partners to identify and define each State-approved business partner staff that may access applications to support the requirements of this contract, along with the appropriate mode (inquiry, update, add) allowed for the application(s) accessed.

SYS - 0008
General
Maintain a State accessible, online, electronic Joint Interface Plan (JIP) that documents all

interfaces to and from TMMIS. The JIP must be provided in a standard format with content and in a media approved by the State. The documentation must include at least the organization owner, the name and phone number of the contact within the organization, the distribution frequency, the interface layout including field definitions and descriptions, the purpose for the file, and a change log. The JIP must be updated within ten (10) business days upon implementation of any change that affects any JIP item. Review all JIPs with HHSC on a quarterly basis or as otherwise requested by the State.

SYS - 0009
General
Host, coordinate, manage and maintain the JIP, eOPM, devices, and sources, such as bulletin boards, websites, and Secure File Transfer Protocol (SFTP) sites. All such JIP, eOPM, and websites are property of the State.

SYS - 0011
General
Maintain the use of a State-approved online data repository for the purpose of receiving provider appeals for Disproportionate Share Hospital (DSH) claims and encounters and sending appeal information back to the providers. CONTRACTOR will archive final versions of DSH appeal claim and encounters appeal templates from providers onto the Local Area Network (LAN), with media and content as defined by the State. The data repository must be accessible by State authorized users.

SYS - 0012
General
Maintain all required web content on websites and portals per State direction, including simple and static text updates. Simple and static text updates are further defined as updates that do not require screen navigation changes, do not require changes to the underlying database, and do not have downstream processing impacts.

SYS - 0201
General
Proactively monitor and notify HHSC when TMMIS capacity is approaching maximums or when performance degradation has occurred and timely offer solutions to increase capacity and improve performance, or as requested by the State.

SYS - 0202
General

EXHIBIT B
Attachment 33
Systems (SYS)

Receive and process EDI transactions in the format as mandated by HIPAA (e.g., X12N and NCPDP post adjudication) addressing subsequent versions via the State-approved change control process with exceptions approved by the State. Process using State-approved edits within timeframes specified by the State.

SYS - 0203
General
Maintain encounter processing edits as directed by the State.

SYS - 0204
General
Maintain, update, and provide to HHSC and State-approved trading or business partners accurate encounter transaction companion guides, submission guides, and other documentation as appropriate in a format and media specified by the State.

SYS - 0205
General
Maintain and provide a data dictionary map as specified by the State. The map will contain definition of all values from EDI and non-EDI sources through processing at the encounter data repository. It will include, at minimum, column names, table names including a complete data hierarchy.

SYS - 0206
General
Store all encounter transactions in the Operational Data Store (ODS).

SYS - 0207
General
Load, maintain, and keep current all related data in TMMIS Operational Data Store.

SYS - 0208
General
Maintain the TMMIS Operational Data Store software, hardware, and database architecture to support State and CONTRACTOR initiated ad hoc queries.

SYS - 0209
General

Allow the user to specify data extraction criteria, sort criteria, and report format/display characteristics for online ad hoc reporting.

SYS - 0210
General
Make available to users an online library/catalog of standardized or frequently used ad hoc queries and selection criteria for routine reports that can be requested and run by authorized State personnel and State-approved business partners.

SYS - 0211
General
Maintain and update all TMMIS Operational Data Store object descriptions and List of Values within seven (7) business days from the availability of the State-approved data source unless otherwise specified by the State.

SYS - 0212
General
Develop, update, distribute, and maintain training materials and deliver training for the TMMIS Operational Data Store functionality (e.g., training curriculum, step by step instructions on producing data queries, and extracts) within timeframes and with content, in a media and format approved by the State. Obtain the State's approval of new user training curriculum prior to performing training.

SYS - 0214
General
Develop and submit a corrective action plan for data extract problems that cannot be corrected within three (3) business days of the date it was identified.

SYS - 0215
General
Correct data extract problems in accordance with State-approved corrective action plan.

SYS - 0216
General
Produce and deliver accurate and verified ad hoc query requests, in a format and media, and within a timeframe approved by the State.

SYS - 0217
General
Provide ongoing operation support to State-approved trading partners to promote successful submission of data. Work one on one with State-approved trading partners to resolve data submission issues.

SYS - 0218
General
Notify HHSC when the CONTRACTOR can reasonably foresee the TMMIS data repository weekend processing deadlines will not be met. (i.e., Vision 21 (V21), weekend processing is not completed by Monday 7:00 a.m. CST).

SYS - 0219
General
Coordinate with State-approved business partners to develop efficient ad hoc queries and extracts, and to verify results.

SYS - 0221
General
Maintain a Capability Maturity Model Integration (CMMI) certification Level 4 or higher through the life of the Contract. The specific rating must be applicable at the business unit level that will be providing the services. Provide the certification level and supporting documentation to HHSC upon completion of each appraisal.

SYS - 0223
General
Maintain certified TMMIS according to Part 11 of HHSC Medicaid Manual and CMS Medicaid Enterprise Certification Toolkit requirements.

SYS - 0224
General
Maintain TMMIS interfaces per State-approved Joint Interface Plans (JIPs).

SYS - 0225
General
Process and deliver the TMMIS interfaces within timeframes based on State-approved Joint

Interface Plan (JIP).

SYS - 0227
General
Maintain a State accessible, online, electronic web services registry that documents external web services. The registry must be provided in a standard format with content and in a media approved by the State. The registry must be updated upon implementation of any change that affects any registry item.

SYS - 0229
General
Notify HHSC of TMMIS deficiencies or processing errors within timeframes based on Priority Levels as defined in the State-approved System Availability and Incident Notification Process.

SYS - 0230
General
Provide secure, online access to authorized users for inquiries, updates, and submissions to TMMIS applications as documented in the State-approved System Availability and Incident Notification Process.

SYS - 0231
General
Manage the OnBase servers for all environments, including performing regular maintenance and applying OnBase updates.

SYS - 0232
General
Configure backups for the OnBase servers and databases for all environments.

SYS - 0233
General
Maintain the application integration between OnBase, CONTRACTOR's imaging and data entry applications, PPM, CRM, PA Workflow, PEP, and PA on the Portal, Phoenix and Compass 21 (C21) and other applications as required by the State.

SYS - 0234
General

EXHIBIT B
Attachment 33
Systems (SYS)

Produce, update and submit to HHSC for review and approval the following documentation, at a minimum, and on a quarterly basis and upon request:

a) Capacity planning reports

b) Asset management reports (including but not limited to: tag number, machine type, and serial number)

c) Application inventory reports (including but not limited to: license and expiration date); and

d) Technology infrastructure inventory.

Templates for reports will be defined by the CONTRACTOR within thirty (30) calendar days of the effective date of the Contract, conforming to established HHSC standards and with the written approval and acceptance by HHSC for the final format. Reports will be submitted in a media, format, content and frequency approved by the State.

SYS - 0235
General
Maintain sixty (60) Acute Care Base Enhancement Team full-time equivalents to plan, develop and implement HHSC projects. Assign a dedicated Portfolio Lead to serve as a technology liaison for HHSC.

SYS - 0236
General
Schedule and prioritize work for the sixty (60) technical Base Enhancement Team full time equivalents (FTE) according to system enhancement priorities determined by HHSC for Acute Care projects.

SYS - 0238
General
Remediate CONTRACTOR defects at no additional cost to the State as documented in the State-approved Maintenance Level Table Description Definition, as follows or as agreed to by the State:

a) Standard 5: Emergency – System no longer functions. Correct within one (1) business day;

b) Standard 4: System Disabled – Business function or components of the business function do not work as required and no workaround is available. Correct within three (3) business days;

c) Standard 3: System Disabled –business function or components of the business function do not work as required, but a workaround that is acceptable to HHSC is available until the problem is resolved. Correct within ten (10) business days;

d) Standard 2: Minor Non-critical problem. Correct within twenty (20) business days; and

e) Standard 1: Minimal Cosmetic. Correct within forty (40) business days.

SYS - 0239
General
Acquisition of hardware or software through procurement or transition processes on behalf of the State or by the State under the terms of this agreement shall be limited to use for State-approved purposes.

SYS - 0242
Enterprise Data Warehouse
Perform on-going back-ups of the Enterprise Data Warehouse (EDW) Staging environment to support Disaster Recovery with EDW source systems consisting of Compass21, LTC-CMS, MedNeedy, Vision21, Encounter ODS, MTP Encounter ODS, Provider Enrollment on the Portal, and Provider Management.

SYS - 0244
Enterprise Data Warehouse
Include EDW in the Disaster Recovery planning/testing to maintain alignment with EDW source systems during an actual Disaster Recovery.

SYS - 0245
Enterprise Data Warehouse
Comply with all HHS MEDG policies, processes, procedures, and standards for EDW data loads of EDW source systems.

SYS - 0246
Enterprise Data Warehouse
Align system enhancements with MITA and EDG processes and policies for EDW data loads of EDW source systems.

SYS - 0247
Enterprise Data Warehouse
Provide continued support for HHS MEDG business logic, technical and business metadata for EDW data loads of EDW source systems.

SYS - 0248
Enterprise Data Warehouse
Apply EDG standards for integration and processing including documentation creation and maintenance of data lineage, business and technical metadata for EDW data loads of EDW source systems.

SYS - 0249
Enterprise Data Warehouse
Provide on-going subject matter expertise to respond to inquiries from HHSC regarding the source system data in the EDW Staging environment.

SYS - 0250
Enterprise Data Warehouse
Maintain and provide on-going updated logical and physical data models with mappings between logical and physical models for EDW source systems in the EDW Staging environment.

SYS - 0251
Enterprise Data Warehouse
Provide on-going monitoring and production support for the EDW Staging environment.

SYS - 0252
General
Maintain the Medicaid/CHIP Data Analytics Platform infrastructure and Tableau Server software including security administration, hardware maintenance, software patches, database connectivity, and troubleshooting technical issues.

SYS - 0254
Enterprise Data Warehouse
Integrate with HHS MEDG change management and data coordination processes related to EDW data loads of EDW source systems.

SYS - 0255
Enterprise Data Warehouse
Verify EDW Staging environment data replication EDW source systems databases during scheduled monthly outages and make verification results available for review.

SYS - 0256
Enterprise Data Warehouse
Notify HHSC of planned and unplanned changes to the EDW Staging environment that would impact the EDW.

SYS - 0257
Enterprise Data Warehouse
Maintain on-going data replication for all tables from the EDW source systems to the EDW Staging environment database.

SYS - 0258
Enterprise Data Warehouse
Provision appropriate security permissions to approved State, EDW Vendor, and CONTRACTOR resources for accessing the EDW Staging environment.

SYS - 0259
Enterprise Data Warehouse
Maintain network connectivity to the EDW Staging CONTRACTOR demarcation point using the HHSC EDW provided circuit for purposes of transferring data from the CONTRACTOR Riata Data Center to the HHSC-EDW target environment.

SYS - 0260
Enterprise Data Warehouse
Maintain a secure EDW Staging environment that is accessible by the EDW for running queries and extracts as needed during scheduled system up-times.

SYS - 0261
General
Perform T-MSIS business rule validations per State-approved processes.

SYS - 0263
Enterprise Data Warehouse
Test interface changes with the EDW using an EDW Staging TEST environment prior to production deployment.

SYS - 0264
Enterprise Data Warehouse

EXHIBIT B
Attachment 33
Systems (SYS)

Notify the HHSC-EDW team of any unscheduled EDW Staging environment system incidents per the State-approved System Incident Notification and Reporting Process.

SYS - 0034
Maintenance
Maintenance Level Table Description Definition, as follows or as agreed to by the State:

a) Standard 5: Emergency – System no longer functions. Correct within one (1) business day;

b) Standard 4: System Disabled – Business function or components of the business function do not work as required and no workaround is available. Correct within three (3) business days;

c) Standard 3: System Disabled –business function or components of the business function do not work as required, but a workaround that is acceptable to HHSC is available until the problem is resolved. Correct within ten (10) business days;

d) Standard 2: Minor Non-critical problem. Correct within twenty (20) business days; and

e) Standard 1: Minimal Cosmetic. Correct within forty (40) business days.

SYS - 0035
Maintenance
Maintain and provide access to State and State-approved business partners an electronic process to track, monitor, and report on all internal or State initiated service requests with content and in a media and format approved by the State. Include the ability to link documentation and/or attachments to the request.

SYS - 0039
Maintenance
Submit an annual TMMIS maintenance schedule by September 1st of each year for State review and approval.

SYS - 0040
Maintenance
Communicate State-approved changes to the maintenance schedule to providers, State-approved business partners and State staff via the web, email and banner messages at least forty-five (45) business days in advance of implementing the change.

SYS - 0041
Maintenance

Submit all requests for unscheduled and emergency TMMIS maintenance to HHSC for approval and consideration to waive the forty-five (45) business day notification period.

SYS - 0043
Maintenance
Notify HHSC at least sixty (60) calendar days prior to the installation or implementation of hardware, software network and data center environmental changes that affect systems utilized by clients, providers, State staff and trading partners.

SYS - 0044
Maintenance
Test all TMMIS software for compatibility with the States' network infrastructure prior to implementing the software.

SYS - 0047
Maintenance
Perform system maintenance and modification tasks and activities. HHSC will not be liable for duplicative cost reporting associated with the same staff resources need to achieve this requirement. Notwithstanding the foregoing, CONTRACTOR may utilize personnel on both base services and Amendments. Hours will be tracked in PPM denoting which tasks personnel worked on.

SYS - 0050
Modifications
Maintain the processes and procedures for managing changes in the TMMIS, including State review, prioritization and approval of work associated with system modifications and maintenance, system enhancements, and new development. Obtain State approval through the change process.

SYS - 0051
Modifications
Conduct detailed requirements analysis for system changes, including recommendations for alternate approaches to meet the State's needs. Present the analysis results to the State, in accordance with the State-approved change process.

SYS - 0052
Modifications

Submit any proposed changes to Statement of Work documents, including changes to staffing, design, development and/or the implementation schedule, including the related pricing, to HHSC for approval.

SYS - 0053
Modifications
Provide a preliminary estimate of the staff effort and scheduling needed to complete each modification, including the impact on other projects and priorities. Submit the results of the preliminary estimate within State specified timeline or timelines as defined in the State-approved change process.

SYS - 0054
Modifications
Complete TMMIS changes in accordance with State-approved dates and priorities established through the change process.

SYS - 0055
Modifications
Coordinate State review and approval of all documentation for system changes by the dates specified in the State-approved project plan for each project.

SYS - 0056
Modifications
Coordinate and implement TMMIS modifications in accordance with State-approved processes and procedures.

SYS - 0057
Modifications
Produce, update and submit to HHSC for review and approval the following deliverables, or as directed by the State, for each system enhancement, new development project, or other projects:

a) Project Work Plan;

b) Monthly Project Status Report;

c) Project Charter and Business and User Requirements (BUR);

d) Requirements Traceability Matrix;

e) Functional Design Documents;

f) Detailed Designed Documents;

g) Architecture Design Documents;

h) Test Approach;

i) Unit/Integration Test Plans and Scripts;

j) System Test Plans and Scripts;

k) User Acceptance Test Plan and Scripts;

l) Project Communication Plan;

m) Risk Mitigation Plan; and

n) Technical Report documentation.

SYS - 0060
Modifications
Perform a walk-through of project deliverables, as directed by the State, for each system change. HHSC must be notified of any substantive changes prior to making the change in the production environment.

SYS - 0061
Modifications
Implement upon State approval all system changes using a State-approved deployment process. Verify the implementation results through monitoring of the production process and correct and document any problems found within State-approved timeframes.

SYS - 0063
Modifications
Submit a monthly report of staff hours charged against system modifications and change orders identified in the automated tracking system.

SYS - 0064
Modifications
Provide a report to HHSC including the total Systems modification effort delivered in support of Agreement requirements (including all executed amendments) and detail on the actual level of effort of hours and hourly labor rates expended on modifications by project (Systems Modification Level of Effort Report) compared to budgeted level of effort by project. The report will include BET projects and COR projects. The BET reporting will include original forecasted

hours and actual hours on each BET project. The COR reporting will include original forecast hours and hourly rates and actual hours and hourly labor rates (for purposes of this requirement, hourly labor rates will be reported as hours by role multiplied by the applicable CONTRACTOR Rate for each role that is forecasted or actually utilized on the COR). Include the actual level of effort expended on Systems modifications year-to-date (Systems Modification Level of Effort Report) compared to budgeted level of effort year to date. The report should be delivered on a monthly basis, in a format and frequency approved by the State.

SYS - 0066
Modifications
Maintain a dashboard related to Electronic Health Record (EHR) Incentive Payment Program to the including: a) Provider Activity Report; b) Registration Summary Report; c) Attestation Summary Report; d) Dispute and Appeals Activity Report; e) Provider Dispute Report; f) Provider Assignment Report; and g) Gauges that updates and displays designated Incentive Program data elements on a periodic basis

SYS - 0067
Modifications
Maintain automated transfers for routing inbound calls to the appropriate destination (specific phone number or TMMIS queue) for the following, but not limited to:

a) MEHIS Client/Provider Help Desk (MEHIS vendor);

b) Texas Health Steps (THSteps);

c) Non-Emergency Medical Transportation (NEMT);

d) Third Party Liability (TPL); and

e) Health Insurance Premium Payment (HIPP).

SYS - 0068
Modifications
Maintain the Extract Transformation and Load (ETL) process for the Health Information Exchange Open Source (HIEOS) repository used to register and store the HL7 documents that are part of Medicaid Eligibility and Health Information Services (MEHIS) System.

SYS - 0241
Modifications

Configure backups for the OnBase servers and databases for all environments.

SYS - 0253
Modifications
Manage the OnBase servers for all environments, including performing regular maintenance and applying OnBase updates.

SYS - 0262
Modifications
Maintain the application integration between OnBase, CONTRACTOR's subcontractor SourceHOV imaging and data entry applications, PPM, CRM, PA Workflow, PEP, and PA on the Portal, Phoenix and C21.

SYS - 0109
Operations
Retain audit logs of systems and user activity as agreed upon with HHSC and in accordance with State-approved Data Security Plan. Upon request, provide to HHSC access reports for systems and user activity within one business day of request. Track patterns of possible unauthorized access attempts.

SYS - 0112
Operations
Maintain State-approved interoperability requirements among systems.

SYS - 0116
Operations
Deliver to HHSC a quarterly Quality Management Assessment Report of CONTRACTOR's information services organization, with content and in a media and format with timeframes approved by the State.

SYS - 0117
Operations
Update and submit for State approval, a comprehensive Business Continuity and Contingency Plan (BCCP), including an asset management process, on an annual basis by the end of the State Fiscal Year (SFY) or as otherwise required by HHSC.

SYS - 0118
Operations
Review and revise the Data Security Plan and submit updates to HHSC for approval annually, by the end of the State Fiscal Year (SFY) or as otherwise required by HHSC.

SYS - 0119
Operations
Restore and recover lost or corrupted data or software in accordance with State-approved processes and procedures.

SYS - 0120
Operations
Notify HHSC within one (1) business day of any corrupt or lost data unless otherwise specified by the State.

SYS - 0122
Operations
Develop a Corrective Action Plan (CAP) and obtain State approval within twenty-four (24) hours after identification of lost/corrupt data unless otherwise directed by the State.

SYS - 0124
Operations
Perform ongoing internal control reviews on the TMMIS' technical operations and notify HHSC within one (1) business day of any deficiencies found during the TMMIS internal control review.

SYS - 0129
Operations
Maintain control totals and processing dates to ensure that all data processing records and interfaces are accounted for on each processing run.

SYS - 0131
Operations
Maintain a verifiable process of checks and balances that ensure accurate data movement between internal TMMIS and applications. Provide demonstrative results to the State within one (1) business day of request.

SYS - 0132
Operations
Propose for State approval backup and recovery procedures that will ensure a methodology for scheduled backups (daily, weekly, monthly) or backups on demand. These procedures will include backup/recovery of such items as: all computer software, operating programs, database tables, files, systems, operations, and user documentation.

SYS - 0137
Operations
Establish and adhere to processing schedule requirements as specified by the State and/or federal requirements.

SYS - 0140
Operations
Monitor and balance all claim time cycles (i.e., daily, weekly, monthly, etc.) to ensure they are accurate and executed correctly. Notify HHSC within twenty-four (24) hours when cycle or job problems are identified.

SYS - 0151
Operations
Maintain up-to-date system operations manuals and procedures and cycle logs with content and in a media and format approved by the State.

SYS - 0152
Operations
In accordance with State directives, maintain accurate, timely and consistent data across all applications where CONTRACTOR has responsibility for data integrity.

SYS - 0153
Operations
Maintain the ability to conduct mass updates and mass adjustments of applicable TMMIS data as approved by the State.

SYS - 0154
Operations
Update the master provider file and the excluded provider file for the Web-based provider look-

up system that is accessed by health care providers and clients.

SYS - 0157
Operations
Maintain a user-accessible crosswalk application (National Provider Identifier (NPI)/Atypical Provider Identifier (API) to Texas Provider Identifier (TPI) and vice versa) and all related documentation.

SYS - 0158
Operations
Maintain the process to crosswalk National Provider Identifier (NPI)/Atypical Provider Identifier (API) to Texas Provider Identifier (TPI) prior to transaction processing for claims and encounters.

SYS - 0159
Operations
Maintain date sensitive processing that allows for a National Provider Identifier (NPI)/Atypical Provider Identifier (API) to map to a different Texas Provider Identifier (TPI) or Contract Number based on changes reported by the provider, National Plan and Provider Enumeration System (NPPES), or DADS.

SYS - 0163
Operations
Maintain the capability to customize and apply the appropriate prior authorization rules for each benefit plan.

SYS - 0165
Operations
Provide an automated secure process to request, maintain, track and report all role-based access to the TMMIS from HHSC with content and in a media and format approved by the State. Process new access requests to the TMMIS from HHSC no later than five (5) business days from request. Process TMMIS access termination requests from HHSC within one (1) hour of request during business hours or otherwise no later than one (1) business day from request.

SYS - 0167
Operations
Maintain and track restriction access information for each TMMIS application, function and

window to specific log-on ID's with role-based security profiles approved by the State.

SYS - 0169
Operations
Establish synchronized user-ID's and passwords for access to the TMMIS when possible, to limit the number of unique user-ID's and passwords across applications.

SYS - 0175
Operations
Ensure the Medicaid EHR Incentive Program web portal is available 99.5% of the time, as measured monthly, with scheduled State-approved downtimes excluded from that calculation.

SYS - 0177
Operations
Provide technical support of National Correct Coding Initiative (NCCI) activities. These activities include monitoring claim transaction throughput between the CONTRACTOR and designated subcontractor, troubleshooting network connectivity issues and support of claim outcome research activities as they relate to NCCI results.

SYS - 0180
Testing
Maintain a testing environment with functions, database tables and files, and data elements in accordance with State-approved processes and procedures.

SYS - 0181
Testing
Make a testing environment available to State staff for User Acceptance Testing (UAT) training and other purposes as defined by the State.

SYS - 0182
Testing
Maintain the ability to test all operational and system functionality prior to implementing changes into the production environment.

SYS - 0184
Testing
Identify or create a representative sample of providers, recipients, and claims records for use in

testing that will verify the integrity of claims processing operations and files based on individual program business requirements.

SYS - 0185
Testing
Maintain sufficient test data in a testing environment to represent all aspects of a business cycle.

SYS - 0187
Testing
Execute claims processing tests in a test environment that fully simulates the production environment. Generate test output, including tables, files, and reports. Test output will be separately identified from production and clearly labeled. Make testing outputs available to HHSC within timeframes specified by the State.

SYS - 0188
Testing
Provide HHSC with online access to test database tables and files which allow HHSC to independently prepare test data, run tests, and review test results.

SYS - 0189
Testing
Provide assistance in preparing test data, running tests, and reviewing test results, as required by the State.

SYS - 0190
Testing
Accept test claims data (paper or electronic media) submitted by HHSC or State trading partners.

SYS - 0191
Testing
Provide access to the test environment and/or test applications for State-approved trading partners.

SYS - 0192
Testing
Perform thorough and rigorous system and integration testing using national industry standards (e.g., National Institute of Standards and Technology (NIST) or Software Engineering Institute

(SEI)) for all changes, including regression testing before changes are promoted to the production environment.

SYS - 0193
Testing
Make system test results available for State review and submitted, as necessary, to other vendors or State-approved business partners for evaluation.

SYS - 0194
Testing
Initiate and conduct walkthroughs of system test changes that are ready to be moved into the production environment. Present a thorough explanation of test cases and results, including a discussion of how all systems and programs are impacted by the system change. Demonstrate online the accuracy of system changes and provide handouts of test results.

SYS - 0195
Testing
Submit walkthrough materials to HHSC for review no later than five (5) business days before the walkthrough unless previously approved by the State. Conduct walkthroughs at the State's discretion.

SYS - 0200
Testing
Provide a written report before production promotions, in a State-approved format, on the results of integrated test cycles within seven (7) business days of running the cycles. Include a comparison of the expected impact of edit, audit, and pricing changes against actual processing results.

EXHIBIT B
Attachment 34
Third Party Liability (TPL)

TPL - 0003
General
Perform TPL activities, as approved by the State, to ensure that Texas Medicaid and/or CSHCN Services Program is the payor of last resort. CSHCN Services Program is the payor of last resort when a client has both Texas Medicaid and CSHCN Services Program coverage. The CONTRACTOR is responsible for overpayments and underpayments in accordance with the contract.

TPL - 0014
General
Respond to TPL inquiries from the State within three (3) business days of receipt and track resolution.

TPL - 0111
General
Research and analyze TPL collection trends, as requested by the State.

TPL - 0126
General
Provide a postage-paid envelope with any communication requiring a mailed response.

TPL - 0132
General
Scan and store electronically all TPL payment, denial, and correspondence documentation.

TPL - 0138
General
Maintain and update client-on-review information.

TPL - 0148
General
Maintain systematic and operational processes to perform all Medicaid Billing Coordination System (BCS) activities as approved by the State.

EXHIBIT B
Attachment 34
Third Party Liability (TPL)

TPL - 0010
Identification
Maintain a process to mail State-approved TPL questionnaires to applicable clients.

TPL - 0029
Identification
Include the OAG-excluded populations in the verification and recovery process. Include the eligible insurance for both the over and under age 18 populations.

TPL - 0038
Identification
Verify TPL prescription drug benefit coverage with carrier/Pharmacy Benefit Manager prior to uploading the coverage data to the Pharmacy Point of Sale (POS) System(s).

TPL - 0050
Identification
Provide information for updates to the Vendor Drug website.

TPL - 0087
Identification
Perform a CHIP data match and submit a report to the State electronically, within timeframes, with content and in a media and format approved by the State, and include:

a) insurance start/end date; b) client name; c) name of the insured, if other than CHIP client; d) insurance company name; and e) other identifying information.

TPL - 0129
Identification
Perform data matching. Current data exchanges are conducted with the following entities: a) Worker's Compensation; b) State Motor Vehicle Accident Report Files; c) Defense Enrollment Eligibility Reporting System (DEERS); d) Medicare HMOs; e) Pharmacy Benefit Manager(s) (PBM); f) Private Insurers; and g) Texas Workforce Commission. CONTRACTOR must be flexible and accommodate additional data matches that may be required to enhance the TPL program and to proactively offer improvements.

TPL - 0130
Identification
Verify TPL information received from all sources except data match to be certain that the

minimum data elements are present to perform cost avoidance and cost recovery activities as approved by the State. Maintain a tracking system to accurately document all TPL information, including all efforts made regarding discovery, identification, and verification of information from all sources except data match.

TPL - 0153
Identification
Perform TPL prescription drug coverage maintenance through carrier/Pharmacy Benefit Manager data matching and other lead sources to provide policy terminations, updates, and deletions on at least a daily basis.

TPL - 0156
Identification
Develop and implement a process to coordinate pharmacy other insurance updates to the appropriate MCOs when client access to care situation are identified. Should the agreed upon solution require the CONTRACTOR to engage additional resources, the parties will jointly pursue an appropriate contracting mechanism.

TPL - 0157
Identification
Perform VDP data matches on the entire population of recipients eligible to receive fee-for-service or managed care Medicaid pharmacy benefits at a minimum frequency of every month.

TPL - 0158
Identification
Perform an HHSC-approved validation process to confirm the quality of the pharmacy other insurance segments delivered during each Service Month. Upon completion of this validation process, the validated segments will be Confirmed Other Insurance Segment Transactions.

TPL - 0004
Recovery
Establish and maintain separate accounts receivable (AR), by program, for credit balance audit recoveries that are not related to coordination of benefits (COB).

TPL - 0012
Recovery
Maintain a process to disposition excess other insurance payments to overage, as approved by

the State.

TPL - 0013
Recovery
Disposition all TPL checks within thirty (30) business days of deposit. Provide a monthly report of exception items including: checks with dispositions in excess of 250 claims, checks without documentation required to post the check, checks waiting on financial cycle to change claim status and corrections as required. At least two (2) attempts must be made to contact carriers/PBMs regarding any missing documentation. Send monthly payout reports in timeframes, format, and media approved by the State.

TPL - 0024
Recovery
Provide the capability to post a paid amount of "$0.00" in the same manner as regular payment amounts are posted, when a carrier pays nothing ("a zero") for services because the client's pharmacy benefits have a deductible and/or coinsurance clause.

TPL - 0025
Recovery
Maintain separate Medicare Part D and regular pharmacy recovery billing and reporting.

TPL - 0027
Recovery
Establish and maintain an electronic billing relationship with insurance carriers and/or Pharmacy Benefit Managers used for billing TPL reclamation claims as directed by the State.

TPL - 0030
Recovery
Perform ongoing follow-up action on recovery billings, including claims that have not received valid dispositions.

TPL - 0031
Recovery
Submit, within State agreed timeframes, TPL reclamation claims to the insurance carrier/PBM for payment recovery when a third party payment source is discovered after Texas Medicaid and/or CSHCN Services Program has paid the claim. If denial information is received from the insurance carrier/PBM, make adjustments as needed and appeal the denial. If it is determined

the carrier/PBM is denying claims inappropriately, escalate the issue(s) to HHSC within the agreed upon timeframes.

TPL - 0057
Recovery
Utilize Encounters for monthly billing of MCO reclamation claims through the use of the existing C21 TPR Client Insurance file and the Managed Care Encounter files contained within V21.

TPL - 0063
Recovery
Create a billing record for each Encounters reclamation claim billed.

TPL - 0064
Recovery
Identify Encounters to be included in the MCO reclamation process no earlier than one-hundred twenty (120) calendar days following the Receipt Date (date of extraction) of the encounter.

TPL - 0065
Recovery
Perform initial and follow-up Encounters billings to other insurance (OI) carriers/PBMs for payment.

TPL - 0131
Recovery
Post all pharmacy recoveries at the claim level for each client.

TPL - 0016
Reporting
Prepare and provide all necessary data and assistance to HHSC in completing the Form CMS-64.9A Report.

TPL - 0049
Reporting
Produce additional VDP TPL coverage information and reports as requested within timeframes, with content, in a media and format approved by the State.

EXHIBIT B
Attachment 34
Third Party Liability (TPL)

TPL - 0084
Reporting
Provide monthly TPL recovery reports to the State and deliver by the 10th calendar day of the following month, with content, and in a media and format approved by the State.

TPL - 0086
Reporting
Submit monthly reports to HHSC, with content and in a media and format and timeframe approved by HHSC which include the following information:

a) Outstanding claims/balances by carrier number;

b) Value of claims with zero payment s;

c) All denials at the claim level, along with the applicable reason code;

d) Carriers that are systematically and inconsistently denying claims;

e) Claims that are rebilled with errors corrected; and

f) Top ten (10) denial reasons.

TPL - 0088
Reporting
Report Medicare identification and recovery activities to HHSC within timeframes, with content, and in a media and format approved by the State.

TPL - 0134
System
Maintain mappings between types of TPL coverage and program covered services for cost-avoidance edits. Analyze the results of cost-avoidance edits and submit recommended changes to the State for approval annually, or as requested by the State.

TPL - 0137
System
Produce TPL client and insurance company electronic files and forward to HHSC contracted MCOs and the Enrollment Broker, according to State-approved timeframes. Limit the amount of file data to the MCO-specific client information.

TPL - 0141
System

EXHIBIT B
Attachment 34
Third Party Liability (TPL)

Provide TPL (client insurance and commercial insurance company) files to the State, within timeframes, with content and in a media and format approved by the State.

TPL - 0151
System
Communicate with providers when a Medicaid Billing Coordination System (BCS) related claim has been re-directed to another carrier via the provider's Remittance and Status (R&S) report.

TPL - 0154
System
Load daily HHSC VDP updates and a complete monthly eligibility file for all in scope Medicaid eligible clients.

TPL - 0155
System
Identify whether another entity or health insurer has primary responsibility for paying the claim within twenty-four (24) hours of claim receipt and submit the claim to that payer through the Medicaid Billing Coordination System (BCS).

TPL - 0019
Tort
Establish and pursue recovery of subrogation amounts for casualty cases within ten (10) business days of receipt of inquiry.

TPL - 0020
Tort
Respond and track subrogation communications within ten (10) business days of receipt.

TPL - 0022
Tort
Provide support for the State as requested regarding subrogation cases.

TPL - 0023
Tort
Take action monthly to identify paid Texas Medicaid and CSHCN Services Program claims that contain State-approved trauma diagnosis codes, and mail State-approved Tort questionnaires to

each identified client.

TPL - 0051
Tort
Archive the Informational Claims once the requirement for an eighteen (18) month hold period expires.

TPL - 0052
Tort
Correspond with providers regarding the Informational Claim process. CONTRACTOR will use State-approved letterhead with content and format approved by the State.

TPL - 0053
Tort
Receive and process provider requests to convert a claim so that it can be considered for payment. CONTRACTOR will use State-approved letterhead with content and format approved by the State for written correspondence regarding this informational claim process.

TPL - 0055
Tort
CONTRACTOR will process the informational claims, which are filed with the CONTRACTOR's TPL department within ninety-five (95) days of the date of service, as defined by the State-approved claims filing deadline calendar.

TPL - 0056
Tort
CONTRACTOR's TPL department will waive the applicable filing deadline when the provider requests the informational claim be converted for payment within eighteen (18) months from the claim's date of service, with the State approval.

TPL - 0116
Tort
Research and open Tort cases that are identified through all sources within ten (10) business days of receipt.

TPL - 0117
Tort

EXHIBIT B
Attachment 34
Third Party Liability (TPL)

Research and resolve all Tort checks within ten (10) business days of receipt.

TPL - 0119
Tort
Perform post-payment follow-up investigations of all open casualty liability cases every six (6) months in accordance with State-approved processes and procedures.

TPL - 0122
Tort
Track provider inquiries regarding Informational Claims.

TPL - 0145
Tort
Calculate medical and prescription claims associated with each Tort case within ten (10) business days from the date the itemized expenditure is ordered.

EXHIBIT B
Attachment 35
Transition (TRN)

TRN - 0001
General
Develop and submit a Detailed Transition Plan to HHSC for approval, no less than ten (10) calendar days after the Contract Effective Date. The Detailed Transition Plan shall adhere to the TMMIS Contract Takeover Transition Guidelines, and include details on the schedule, activities, and resource requirements associated with all transition tasks including those added in contract discussions. CONTRACTOR may leverage existing materials and update as necessary.

TRN - 0002
General
Present evidence of an active Third Party Administrator license, as required by Texas Insurance Code, Chapter 4151, from the Texas Department of Insurance within ten (10) business days of the contract Operational Start Date.

TRN - 0005
General
Establish a secure TMMIS Project Management Portal that serves as the electronic repository for documents and deliverables resulting from the official TMMIS Transition Phase.

TRN - 0011
Processes and Procedures
Develop criteria and a risk assessment tool to identify and weight the risk of a Change Order Request ("COR") for consideration during subsequent COR development.

TRN - 0010
Quality Management
During the Transition period, CONTRACTOR will perform an assessment of quality assurance activities and report on the outcomes and improvements resulting from:

a) Identifying applicable non-designated hard deliverables;

b) Identifying common patterns of errors from previously submitted deliverables in the document creation and quality review steps;

c) Review and revise the quality review/peer review processes;

d) Confirm resource allocation towards quality peer review processes; and

e) Train impacted resources on revised quality assurance process.

TRN - 0006
Staffing
Appoint, with State approval, an executive sponsor and project manager to direct and coordinate all Transition activities.

TRN - 0007
Staffing
Locate all TMMIS transition staff at the TMMIS permanent facility unless HHSC grants an exception.

TRN - 0008
Staffing
Establish a TMMIS Transition Project Management Office (PMO) at the TMMIS permanent facility site in Austin, Texas, within ten (10) calendar days from the Effective Date. The TMMIS Transition PMO shall be managed by a CONTRACTOR Transition project manager.

TRN - 0009
Staffing
Identify and submit to HHSC for approval a list of designated Key Personnel for Transition Phase activities and ensure that such Key Personnel are allocated to the Contract and on-board at the start of the Contract, unless otherwise approved by the State.

EXHIBIT B
Attachment 36
Turnover & Contract Closeout (OVR)

OVR - 0001
Turnover
Maintain the performance and services obligations during turnover activities.

OVR - 0002
Turnover
Provide a list of designated Key Personnel for Turnover and Contract Closeout activities (collectively "KPT") and ensure that such key personnel are 100%, exclusively allocated to the Contract and Turnover activities unless otherwise approved by the State. Key Personnel must be full time personnel that are qualified, experienced and knowledgeable of the Contract. Any redirection of Key Personnel to perform functions other than the responsibilities of the positions identified for this contract, either temporarily or permanently, will require prior State approval. HHSC reserves the right to approve the hiring of any KPT, CONTRACTOR staff, or subcontractor employee.

OVR - 0003
Turnover
Replace any KPT, CONTRACTOR employee or subcontractor employee found unacceptable to HHSC during the Turnover and Contract Closeout as required by the State. The individual must be removed immediately upon State request for removal.

OVR - 0004
Turnover
Obtain State approval prior to any redirection of KPT to perform functions other than the Turnover and Contract Closeout responsibilities of the positions identified for the Contract, either temporarily or permanently.

OVR - 0005
Turnover
Appoint, with State approval, a project manager to direct and coordinate all turnover activities. CONTRACTOR shall not reduce operational staffing levels during the turnover period without prior approval from HHSC and will not restrict or prevent CONTRACTOR staff from accepting employment with any Successor Contractor.

OVR - 0006
Turnover

EXHIBIT B
Attachment 36
Turnover & Contract Closeout (OVR)

As part of Turnover, provide to HHSC or its agent, within fifteen (15) business days of the request, all updated computer programs, data and reference tables, scripts, and other documentation and records required by HHSC or Successor Contractor to operate the TMMIS and to perform operations for the Turnover and Closeout period.

OVR - 0007
Turnover
Implement the State-approved Turnover Plan within timeframes as directed by the State.

OVR - 0008
Turnover
Train State staff or any State-designated agent in the operation of systems and business processes during the Turnover time period within a timeframe specified by the State.

OVR - 0009
Turnover
Provide all known updates or replacements to business, operations, and technical materials not yet formally documented during the Turnover time period as directed by the State.

OVR - 0010
Turnover
Provide a Turnover Results Report to HHSC after the turnover of operations as defined in the Turnover Plan, with content, media, format, and in a timeline approved by the State. The Turnover Results Report must document the completion and results of each step of the Turnover Plan. Turnover will be considered complete when this document is approved by the State.

OVR - 0011
Turnover
Provide the services of an onsite, manager level employee who has worked on the Contract for at least one (1) year and who has access to other technical experts within the CONTRACTOR's corporate structure during the Turnover and Contract Closeout period and beyond. This individual will be required to be onsite for at least ninety (90) calendar days following completion of Turnover. The individual proposed by the CONTRACTOR must be approved by the State. HHSC will provide working space and will assign work to be done on a full time basis to support post turnover activity.

EXHIBIT B
Attachment 36
Turnover & Contract Closeout (OVR)

OVR - 0012

Turnover

Submit a Turnover Plan within timeframes, format, content, and media approved by the State.

EXHIBIT B
Attachment 37
Key Measures

Pursuant to Section 10.03 of the Agreement, CONTRACTOR will achieve the following Key Measures and may have liability for liquidated damages for its failure as further described under each Key Measure. Certain Key Measures also have the potential for CONTRACTOR to earn incentives where indicated. If CONTRACTOR meets the parameters to earn an incentive, such payment will be invoiced and paid in the next applicable month and will be independent of the RCS Ceiling and any maximum amount of Fees to be paid to CONTRACTOR under the Agreement.

For purposes of these Key Measures, all measurement periods shall be monthly unless otherwise specified herein. Additionally, when a Liquidated Damage refers to a percentage point, or portion thereof, the "portion thereof" means that a full percentage point deviation is not required to assess the Liquidated Damage. For avoidance of doubt, the "portion thereof" shall not act as a multiplier of the Liquidated Damage. For example, if the standard is 99% and the results achieved are 98.6%, the Liquidated Damage that may be assessed is based on 1%. The next interval to assess would be 97.9%.

ACR - 0019
Administrative Appeals - Tier 2
Completely research and respond to 95% of provider administrative appeals no later than thirty (30) calendar days from the date of CONTRACTOR receipt. Completely research and respond to the remaining 5% within sixty (60) calendar days from the date of CONTRACTOR receipt.

Liquidated Damage: The State may assess up to $5,000 for each percentage point, or portion thereof, for failing to completely research and respond to: (a) 95% of provider administrative appeals within thirty (30) calendar days; and (b) the remaining 5% of provider administrative appeals within sixty (60) calendar days.

ACR - 0007
Client and Provider Complaints - Tier 1
Answer 100% of legislative inquiries no later than eight (8) business hours from receipt of the request or provide a plan to obtain the information with an estimated time of completion agreed to by the State.

Liquidated Damage: The State may assess up to $1,000 per hour for each occurrence of a late response exceeding the standard.

ACR - 0009 (PENDING - ED +90)
Client and Provider Complaints - Tier 1

Resolve 95% of complaints no later than ten (10) business days from receipt. Resolve the remaining 5% no later than fifteen (15) business days from receipt.

Liquidated Damage: The State may assess up to $2,500 for each percentage point, or portion thereof, for failing to meet the applicable 95% standard within ten (10) business days from receipt.

ACR - 0026 (PENDING - ED +90)
General - Tier 1
Process 98% of administrative appeal related claims (i.e., requests entered into PPM by HHSC as an AAC type request) no later than ten (10) business days or as directed by the State from the date the request is created and submitted to CONTRACTOR. Process remaining 2% within thirty (30) business days or as directed by the State.

Liquidated Damage: The State may assess up to $5,000 for each percentage point, or portion thereof, for failing to process 98% of administrative appeal related claims within ten (10) business days or as directed by the State. In the event that there are less than one-hundred (100) administrative appeal-related claims processed in a Service Month, the KM will be reported in the subsequent Service Month in which the cumulative number of administrative appeal related claims exceeds one-hundred (100) claims processed.

CCC - 0029
Client Services - Tier 1
Call blockage rate for each client line at all levels (e.g., answered by busy signals, disconnections, or other technical problems that prevent the caller from receiving help from staff as a result of blockage at the trunk level or any other time prior to entry to the queue) will not exceed 2%, calculated and reported on a monthly basis. "Answer" may be by live person or automated system.

Liquidated Damage: The State may assess liquidated damages as specified in the calculation method applicable to this Key Measure. The specific liquidated damage for each line shall be based on line volume and may be assessed for each percentage point, or portion thereof, exceeding 2% standard for call blockage.

For each line grouping as specified in the calculation method applicable to this Key Measure, the State may assess up to $5,000 for each percentage point, or portion thereof, exceeding the 2% standard for call blockage.

EXHIBIT B
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Key Measures

CCC - 0036
Client Services - Tier 1
For each client line, the call abandonment rate (in which the caller disconnects prior to the call being answered by a customer service representative) will not exceed 5%.

Liquidated Damage: The State may assess liquidated damages as specified in the calculation method applicable to this Key Measure. The specific liquidated damage for each line shall be based on line volume and may be assessed for each percentage point, or portion thereof, exceeding the 5% standard for call abandonment.

For each line grouping as specified in the calculation method applicable to this Key Measure, the State may assess up to $5,000 for each percentage point, or portion thereof, exceeding the 5% standard for call abandonment.

CCC - 0060
Client Services - Tier 1
Provide call center staff to answer all Medicaid Statewide Helpline calls (in English and Spanish) with a "live" person, within a monthly maximum average response of three-hundred (300) seconds, whether the call is initially answered by Automated Call Distribution (ACD) or other telephone call routing equipment.

Liquidated Damage: The State may assess up to $10,000 for each month the standard is not met.

CCC - 0050
General - Tier 2
Maintain a call center first call resolution rate of 90% for each client and provider line.

Liquidated Damage: For each line grouping as specified in the calculation method applicable to this Key Measure, the State may assess up to $5,000 for each percentage point, or portion thereof, below the 90% standard.

CCC - 0062
General - Tier 1
Maintain a sixty (60) second monthly average speed to answer (ASA) per line as measured by the time in queue before being answered by a "live" person, for all toll-free lines excluding Healthy Texas Women Program and Third Party Liability (TPL) lines.

EXHIBIT B
Attachment 37
Key Measures

Liquidated Damage: The State may assess liquidated damages as specified in the calculation method applicable to this Key Measure. The specific liquidated damage for each line shall be based on line volume and may be assessed for each line that exceeds the standard.

For each line grouping as specified in the calculation method applicable to this Key Measure, the State may assess up to $5,000 for each grouping that exceeds the standard.

CCC - 0149
Provider Services - Tier 1
Call blockage rate for each provider line at the trunk level will not exceed 2%.

Liquidated Damage: The State may assess liquidated damages as specified in the calculation method applicable to this Key Measure. The specific liquidated damage for each line shall be based on line volume and may be assessed for each percentage point, or portion thereof, above the standard.

For each line grouping as specified in the calculation method applicable to this Key Measure, the State may assess up to $5,000 per percentage point, or portion thereof, above the standard.

CCC - 0158
Provider Services - Tier 1
Maintain a call deflection rate of no more than 6% for provider call lines, or an agreed upon threshold.

Liquidated Damage: The State may assess up to $2,500 for each percentage point, or portion thereof, above an 8% standard on a monthly basis for failure to meet the requirement.

CCC - 0160
Provider Services - Tier 1
Maintain a one-hundred and twenty (120) second monthly average speed to answer (ASA) per line as measured by the time in queue before being answered by a "live" person, for the Healthy Texas Women client and provider lines.

Liquidated Damage: For the client and provider lines as specified in calculation method applicable to this Key Measure, the State may assess up to $5,000 for each line grouping that exceeds the standard.

CPC - 0016
Processing - Tier 1
Adjudicate 98% of all clean claims, as defined by CMS, (paper and electronic) within thirty (30) calendar days of the date of receipt. Adjudicate 99% of all clean claims (paper and electronic) within ninety (90) calendar days of the date of receipt. Adjudicate all other claims (paper and electronic) within twelve (12) months of the date of receipt. This Key Measure will be measured monthly and excludes Long Term Care claims.

Liquidated Damage: The State may assess up to $5,000 for each percentage point, or portion thereof, for failing to adjudicate 98% of clean claims (paper and electronic) within thirty (30) calendar days of the date of receipt.

The State may assess up to $5,000 for each percentage point, or portion thereof, for failing to adjudicate 99% of all clean claims (paper and electronic) within 90 calendar days of the date of receipt.

CPC - 0042
Processing - Tier 1
Reprocess 98% of claims that were incorrectly paid or denied within thirty (30) calendar days of discovery or as directed by the State. Reprocess 100% within fifty (50) calendar days of discovery or as directed by the State.

Liquidated Damage: The State may assess up to $5,000 for each percentage point, or portion thereof, for failing to reprocess at least 98% of incorrectly paid or denied claims within thirty (30) calendar days of the date of discovery.

CPC - 0054 (PENDING - ED +180)
Encounter Processing - Tier 1
Provide the State weekly reporting of fatal and warning business edits of state specified criteria on the agreed upon schedule.

Liquidated Damage: The State may assess up to $1,500 per day for each day beyond the scheduled due date that the report is not delivered.

EXHIBIT B
Attachment 37
Key Measures

CPC - 0055
Processing - Tier 2
Perform a quality assurance (QA) review on a stratified random sample of finalized claims for each State program, except LTC, to validate that at least 98% of claims are accurately processed for each program; using a schedule that is approved by the State.

Liquidated Damage: The State may assess up to $5,000 for each percentage point, or portion thereof, for failing to meet the 98% standard.

CPC - 0121 (PENDING - ED +90)
Processing - Tier 1
Process 99.8% of Long Term Care electronic claims within three (3) calendar days and 100% of Long Term Care electronic claims within five (5) calendar days after receipt of the claim via EDI or TexMedConnect.

Liquidated Damage: The State may assess up to $5,000 for failing to meet the 3-day standard or up to $15,000 for failing to meet the 5-day standard. Only one LD may be assessed in a given Service Month.

CPC - 0130 (PENDING - ED +90)
Processing - Tier 1
Process 99.8% of Long Term Care claims accurately.

Liquidated Damage: For each occurrence of a defect within the CONTRACTOR's control that impacts claims accuracy amounts, the State may assess up to $10,000 for defects that affect more than 500 claims, and up to $20,000 for defects that affect more than 10,000 claims. LDs shall be assessed on a per-occurrence basis and therefore in a given month there could be more than one LD applied if more than one defect impacting claims accuracy is discovered in a given month. An applicable defect can be assessed a maximum of one LD regardless of the number of months the defect existed. For purposes of assessment of CPC-0130, applicable defects are specific deviations from requirements documented in the applicable BUR/FD associated with the Claims Management System (CMS) and include Standard 3, Standard 4, and Standard 5 maintenance categories as defined in requirement SYS-0034. Defect severity is assessed by CONTRACTOR and is contingent upon State agreement.

EXHIBIT B
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Key Measures

FHC - 0016
General - Tier 2
Achieve no less than ninety-eight percent (98%) accuracy rate for the completed Request for Fair Hearing Document.

Liquidated Damage: The State may assess up to $2,000 for each percentage point, or portion thereof, for failing to meet the 98% standard.

FES - 0035
General - Tier 1
Assign a unique control number to 99.5% of digital documents received by the mailroom within one (1) business day of receipt. Assign a unique control number to all digital documents received by the mailroom within two (2) business days of receipt. The unique control number must be associated to every page of the digital document. Attachments must receive the same unique control number as the document to which they are attached, and must remain with such document.

Liquidated Damage: The State may assess up to $500 for each percentage point, or portion thereof, for failing to meet the 99.5% standard for control number assignment within one (1) business day after receipt of digital documents.

FES - 0036
General - Tier 1
Process (receive, prep, scan, and index) paper prior authorization (PA) requests no later than one (1) business day from date of receipt by the mailroom 98% of the time. Process (receive, prep, scan, and index) 100 % of paper prior authorization (PA) requests no later than two (2) business days from date of receipt by the mailroom.

Liquidated Damage: The State may assess up to $5,000 for each percentage point, or portion thereof, below the 98% standard on a monthly basis for failure to meet the requirement.

FES - 0037
General - Tier 2
With the exception of the ACA checks that require an application identifier and all TORT checks (which must be validated prior to deposit for legal reasons), deposit 98% of all checks received by the mailroom into the appropriate HHSC bank account within one (1) business day of receipt

by the mailroom. Deposit 100% of all checks (except the aforementioned exclusions) received by the mailroom into the appropriate HHSC bank account within three (3) business days of receipt by the mailroom.

Liquidated Damage: The State may assess up to $1,000 for each percentage point, or portion thereof, below the 98% standard on a monthly basis for failure to meet the requirement.

FES - 0038
General - Tier 2
Key 98% of paper claims within five (5) business days. Key 100% of paper claims within ten (10) business days. Business days will be measured from date of receipt by the mailroom until data entry is complete.

Liquidated Damage: The State may assess up to $1,000 per each percentage point, or portion thereof, below 98% standard on the monthly basis for failure to meet the requirement.

FMG - 0013
Processing - Tier 1
Complete Compass 21 provider claim payment processing on the schedule agreed with the State.

Liquidated Damage: For any cycle not complete within one (1) business day of the agreed date, the State may assess up to $5,000. If the cycle is processed between (3) three and (5) five business days late the State may assess up to $10,000. If the cycle is processed more than five (5) business days late the State may assess up to $25,000.

GOC - 0239 (PENDING - ED +90)
Reporting - Tier 1
Provide a monthly Key Measure Report package that meets accuracy standards per State-approved criteria.

Liquidated Damage: The State may assess $5000 for the initial monthly package delivery that does not meet accuracy per State approved criteria, and $2000 for each subsequent submission that does not meet the standard. Newly effective KMs are exempt from the accuracy standard of this requirement during the first month in which such KM is reported.

HIP - 0001
Reimbursement - Tier 1
Issue HIPP and IPPA check writes twice weekly on a schedule agreed with the State.

Liquidated Damage: The state may assess up to $2,500 per occurrence for failing to meet the twice weekly standard.

HIP - 0027
Reimbursement - Tier 1
Accurately reimburse HIPP and IPPA payments to the correct payee 99% of the time.

Liquidated Damage: The State may assess up to $2,500 for each percentage point, or portion thereof, for failing to meet the 99% standard.

LTC - 0242
Online - Tier 2
Correctly determine manually processed medical necessity determinations rendered by nurses.

Liquidated Damage: The State may assess up to $500 for each occurrence of an incorrect determination.

MDP - 0072 (PENDING - ED +90)
Research, Analysis and Development - Tier 1
The final draft medical/dental policy is no less than 95% accurate, as determined by the quality review performed by CONTRACTOR based on the State approved measurement methodology.

Liquidated Damage: The State may assess up to $500 for each percentage point, or portion thereof, for failing to meet the 95% accuracy standard.

PAC - 0052 (PENDING - ED +90)
Processing - Tier 1
For prior authorization service requests, with the exception of non-emergency ambulance requests, submitted with complete information (defined as a request that was not rejected or pended for missing or additional information), 98% of the time CONTRACTOR will disposition the request (e.g., approve, deny, pend to physician/dentist, modify, void or duplicate) no later than three (3) business days from the date of receipt.

Liquidated Damage: The State may assess up to $5,000 for each percentage point, or portion thereof, below the 98% standard.

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Attachment 37
Key Measures

PAC - 0093 (PENDING - TSD +90)

Processing - Tier 1
Achieve not less than 98% accuracy for completed prior authorizations based on State-approved policies for medical necessity and covered services, unless the State specifically directs otherwise.

LD Language: This Key Measure includes reporting of both Medical Necessity compliance and covered services compliance as two separate scores. In the event that either score falls below the 98% standard, the State may assess up to $10,000 for each percentage point, or portion thereof, below the 98% standard for one, but not both scores.

PAC - 0094

Processing - Tier 2
Send a prior authorization denial letter to the client, no later than five (5) Business Days after a prior authorization service denial or modification of a service request no less than 98% of the time. Send 99.8% of prior authorization denial letters no later than ten (10) Business Days after a prior authorization service denial or modification of a service request.

Liquidated Damage: The State may assess up to $2,000 for each percentage point, or portion thereof, below the 98% standard. The State may assess up to $2,500 for each percentage point, or portion thereof, below the 99.8% standard. When both performance targets are not met, the State may assess the lesser of the two damages, not both.

PAC - 0096
Processing - Tier 1
For prior authorization service requests, with the exception of non-emergency ambulance requests and those requiring physician/dentist review, 95% of the time the Contractor will determine and document the final disposition (e.g., approve, deny, modify, void, or duplicate) no later than 15 business days from the date of receipt.

Liquidated Damage: The State may assess up to $5,000 for each percentage point, or portion thereof, below the 95% standard.

PRV - 0088
Enrollment - Tier 1
Maintain a minimum of 98% accuracy rate for processing provider enrollment applications, which is measured against State-approved criteria.

EXHIBIT B
Attachment 37
Key Measures

Liquidated Damage: The State may assess up to $10,000 for each percentage point, or portion thereof, below the 98% standard for accuracy.

PRV - 0089 (PENDING ED+180)
Enrollment - Tier 1
Complete program enrollment application processing, within the specified performance targets and end-to-end enrollment timeframes by Initial Application State (i.e., clean, deficient) and Provider Type (i.e., Individual, Performing Provider, Group Facility) as follows:

Initial Application State	Provider Type	Performance Target	Incentive Target	End-to-End Provider Enrollment Timeframe
Clean	Individual	NN%	NN%	NN Business Days
Clean	Performing Provider	NN%	NN%	NN Business Days
Clean	Group	NN%	NN%	NN Business Days
Clean	Facility	NN%	NN%	NN Business Days
Deficiency	Individual	NN%	NN%	NN Business Days
Deficiency	Performing Provider	NN%	NN%	NN Business Days
Deficiency	Group	NN%	NN%	NN Business Days
Deficiency	Facility	NN%	NN%	NN Business Days

Liquidated Damage: In the event that any of the Provider Type Performance Targets are missed in a Service Month, the State may assess up to $5,000 for each percentage point for one of the Provider Types that missed the Performance Target.

Incentive: In the event that the Contractor performs above the Performance Target for all Provider Types in a Service Month, the State may apply an incentive of $5,000 for each percentage point above the Incentive Target for the lowest performing (i.e., smallest deviation above Incentive Target) Provider Type.

PRV - 0407 (PENDING ED +90)
Enrollment - Tier 1
Maintain a minimum 98% accuracy rate for State-specified provider maintenance data elements

post enrollment entered by CONTRACTOR into the system. State-specified provider maintenance data elements for this measure are Federal Tax ID number, ownership or control interest, and provider licensure, certification, and accreditation.

Liquidated Damage: The State may assess up to $5,000 for each percentage point, or portion thereof below the 98% standard.

PRV - 0418
General - Tier 2
Complete pre-enrollment site-visits for 95% of all applicable provider enrollment applications within ten (10) business days of a determination that a pre-enrollment site visit is needed. Complete pre-enrollment site-visits for 100% of all applicable provider enrollment applications within twenty (20) business days of a determination that a pre-enrollment site visit is needed or as directed by the State.

Liquidated Damage: The State may assess up to $5,000 for each percentage point, or portion thereof below the 95% standard.

PRV - 0419
General - Tier 2
Maintain a minimum 95% accuracy rate for complete provider enrollment applications sent to HHSC/IG for processing, which is measured against State-approved criteria.

Liquidated Damage: The State may assess up to $500 for each percentage point, or portion thereof below the 95% standard.

SYS - 0213
General - Tier 1
Correct all data extract delivery and content problems within five (5) business days of problem identification, or another timeframe as mutually agreed within the five (5) business days of problem identification, and notify the State of correction. Data extracts are documented in the Joint Interface Plan (JIP).

Liquidated Damage: The State may assess up to $5,000 per day for failure to meet the timeliness standard.

SYS - 0226
General - Tier 1
Process and deliver 99% of the Priority One Interfaces set forth in Attachment 42 to this Exhibit

B within timeframes based on State-approved Joint Interface Plan (JIP).

Liquidated Damage: The State may assess up to $5,000 for each percentage point, or portion thereof, below the 99% standard.

SYS - 0033
Maintenance - Tier 1
Maintain 98% uptime for all TMMIS Priority One system applications as a group, except for planned State approved downtime.

Liquidated Damage: The State may assess up to $10,000 for each percentage point, or portion thereof, below the 98% standard.

TPL - 0011
General - Tier 2
Enter updates to 98% of TPL resource information, from all sources, no less than five (5) business days from receipt by the TPL department and no later than ten (10) business days from receipt for updates requiring additional verification. Enter the remaining 2% no later than thirteen (13) business days from receipt.

Liquidated Damage: The State may assess up to $5,000 for each percentage point, or portion thereof, below the 98% standard.

TRN - 0003
General - Tier 1
Complete key Contractor transition tasks no later than ninety (90) calendar days from the Transition Start Date, unless otherwise specified. Key contractor transitions tasks are to:

a) Establish Transition Project Manager and Key Personnel.

b) Submit Transition Work Plan for State approval.

c) Renewal of TPA Licenses.

d) Submit DEDs for new Transition Deliverables for State approval.

e) Submit for State approval and confirmation of new and revised Contract Requirements (CRs) and Key Measures (KMs).

f) Complete a Contract Requirement Impact Analysis for new and revised CRs and KMs.

g) Submit Final Process and Calculation Methodology Documents for new and revised Key Measures.

h) Complete Operational Readiness Assessment for new and revised CRs and KMs that are to be effective on or before the Transition Start Date.

i) Submit an updated Accounting Policy Manual within thirty (30) business days of Effective Date of the Agreement for State review.

j) Implement Invoicing process to support new monthly billing process.

Liquidated Damage: The State may assess up to $25,000 per business day for failure to meet the completion of key transition tasks by the specified date.

EXHIBIT B
Attachment 38
Medical Policy Services and Definitions

CONTRACTOR and HHSC have agreed to the following definition of the scope of support that CONTRACTOR will provide as part of the Services under the Agreement. The definitions will be used as the basis to measure the level of support that can be provided each quarter for medical policy implementation services. The level of support will vary by quarter to accommodate periodic updates that are required to keep code sets current.

The parties have agreed that CONTRACTOR will provide an annual implementation capacity of one-hundred (100) Comprehensive and Targeted reviews as defined herein. These reviews will be provided throughout the year at varying levels such that the CONTRACTOR supports an implementation capacity of twenty-five (25) policies per quarter on average across each Operational Contract Year for Targeted and Comprehensive reviews. CONTRACTOR will notify HHSC if the number of reviews requested by HHSC is exceeding the capacity and the 100-review annual limit and present options to support HHSC's needs in this area.

The process to research and implement Clinical Policy changes in support of the management of Medical Policy affects and is supported by several teams:

- CONTRACTOR Medical Policy Support (MPS)
- CONTRACTOR Reference Data Maintenance (RDM)
- CONTRACTOR Document Research Team (DRT)
- CONTRACTOR Provider Publications
- CONTRACTOR Prior Authorization
- CONTRACTOR Claims
- CONTRACTOR Technology Services
- HHS

Definitions

The defined term for Clinical Policy provides the foundation to determine the number of Clinical Policy Updates that are performed in a quarterly period.

"Clinical Policy" - A guideline for determining coverage criteria for specific medical, dental or behavioral health technologies, including procedures, equipment, and services. Clinical Policy is developed and approved by the State, and is implemented for State services, including but not limited to, the Medicaid and CSHCN Services Program. The following activities, although not an exhaustive list, are not considered making or promulgating Clinical Policy:

- Updates occurring as part of the HCPCS, ICD, or NCCI reviews;

- Clinical coding research upon request by the HHS stakeholder (e.g., request to review comparable code pricing, modifier research, Federal Register changes, etc.) as defined by the contract requirements);
- Pricing requests for procedure codes the State is considering as a benefit
- Minor policy language edits (e.g., proofreading, formatting, grammatical changes, typos) that have no impact to TMPPM, notifications, transactional processes, publications, or research.

A single Clinical Policy Update is defined as an entry in the eOPM Table of Contents. Separate Clinical Policies exist for each of the HHSC Programs.

Clinical Policy Updates affecting multiple HHSC Programs shall be counted as separate, regardless of whether it affects the same policy.

NOTE: Examples notating State Action Requests (SAR) provided below are sourced from HHSC formal correspondence repository (i.e., MCATS) for the predecessor contract for claims administration.

For example:

One SAR will have multiple MPS PPM #s associated due to different programs impacted.

Medicaid will submit a SAR with policy direction. The Contractor will create an MPS PPM # and will reach out to CSHCN for alignment of their program. CSHCN will agree and the Contractor will create a CSHCN PPM# associated for that SAR direction. (Ex: SAR # 75190 Anesthesia Services Policy Changes to Align with Rate Changes. Two separate PPM #'s were created – PPM# 6086301 for Medicaid and PPM # 6115966 for CSHCN). This counts as two single/separate Clinical Policy Updates.

OR

One SAR will have multiple MPS PPM #s for the same program because there is impact to multiple policies.

A SAR that is received with direction (or requires) to update more than one Clinical Policy. (Ex: SAR #65383-1 for which multiple MPS PPM #s were generated because multiple policies were being updated - PPM# 5391417-PLS – Microbiology, PPM# 5408573- HIV Drug Resistance Testing and PPM # 5406353 Gynecological and Reproductive Health Services.) This counts as three single/separate Clinical Policy Updates.

EXHIBIT B
Attachment 38
Medical Policy Services and Definitions

Multiple updates to a single Clinical Policy will be counted separately unless submitted by the State with the same Medical Policy Support PPM ID number and the updates have no impacts to implementation date.

For example:

> Multiple associated SARs with one PPM # with a future implementation date affecting one Clinical Policy.
>
> The initial SAR received directs the Contractor to update a clinical policy with a future implementation date. A separate SAR is later received with direction to make additional updates and does not impact the original implementation date. The second and separate SAR references the initial SAR and implementation date. (Ex: SAR #65222-1 and SAR #69114-1 for Non-Invasive Prenatal Testing. One PPM ticket was created although multiple SARs were received with two separate requests for update to the same policy. This is considered one Clinical Policy Update.

OR

> Multiple associated SARs with two PPM #s with two future implementation dates affecting one Clinical Policy.
>
> The initial SAR received directs the Contractor to update a clinical policy with a future implementation date. A separate SAR is later received with direction to make additional updates. The second and separate SAR references a different implementation date than the initial SAR. (Ex: SAR #67129-1 and SAR # 71433-1 for PT-OT-ST Adult. One PPM ticket was created for SAR #67129-1 and another for SAR# 71433-1 although it was an update to the same policy.) This is considered two Clinical Policy Updates.

Categorization of Clinical Policy Updates

Clinical Policy Updates are designated as a Language Only, Targeted, or Comprehensive review defined as follows:

- **Language Only:** Review will be limited to adding or changes of language within a clinical policy and not require updates to systems, adjudication guideline, Process or Procedures, and/or job aids.
- **Targeted:** Review is limited to the specific reason for referral by HHSC and will include updates to no more than three (3) policy language topics, updates to system coding, adjudication guidelines, Processes and Procedures and/or job aids. Technology updates are not considered within the scope of a targeted review. Any additional items or

technology updates identified during the review may result in the review being upgraded to Comprehensive.

- **Comprehensive:** Review consists of four (4) policy language topics up to its entirety and requires updates to system coding, adjudication guidelines, Process and Procedures, job aids and/or technology enhancements. Comprehensive review can consist of reviews that were upgraded based on the Targeted definition.

For the purposes of clarity, operational and/or technology changes resulting from policy updates will follow the established contractual provisions and procedures for change management in the Agreement for such changes.

EXHIBIT B
Attachment 39
Key Assumptions

1	The Medicaid program will continue to exist in the same general form as constituted as of the Effective Date, subject to the types of historical policy changes envisioned by the Changes in Law provisions of the Agreement.
2	Future termination of services, programs or functional areas by HHSC may not result in a reduction in the fixed fee contract amount equal to the current allocation for a specific line item. For example, the allocation of facility costs by area or program may not result in a dollar for dollar reduction due to the structure of the lease agreement and usage of the space. The impact of the termination of services, programs or functional areas will need to be jointly assessed by the parties at the notice of intent to terminate a component by HHSC.
3	CONTRACTOR will determine the manner and method in which it performs the Functional Requirements and Key Measures, acting in accordance with the Agreement. The Parties will make good faith efforts to resolve any conflicts during Transition.
4	Any amendments from the predecessor contract that are not listed in Exhibit D that continue beyond the July 31, 2017 will be incorporated via Amendment prior to August 1, 2017.
5	High-risk and moderate-risk providers require a pre-site and post-site visit. Post site visits are flexible to perform between six (6) and twelve (12) months post enrollment.
6	Pricing for the HW/SW and Pass-through items has been estimated based on current pricing with appropriate cost adjustments based on historical trends. The actual costs for these items will likely vary from the proposed pricing.
7	CONTRACTOR's Fees assume no subcontractors are Primary Subcontractors, and therefore, no Subcontractors will be subject to separate RCS processes.
8	CONTRACTOR's HW/SW pricing assumes that HHSC will continue to move forward with allowing CONTRACTOR to decommission Oracle JCAPS, which was put in place to support identification of Medicaid recipients on lab transactions using only the person's demographic information. Since HHSC is moving away from this process, CONTRACTOR plans to decommission JCAPS in FY18 and discontinue paying maintenance after that point.

EXHIBIT B
Attachment 40
Systems Application Inventory

TMMIS systems are grouped into three availability times: 23x7, 13x7, and 13x5. Systems are available during the established system operating hours except during approved maintenance and release schedules. The Table below outlines the system availability by application availabity times.

Availability Operating Hours	**TMMIS system - 98% availability measured monthly**
Priority 1 23x7 23 hours daily except 3am - 4am	AIS (Automated Inquiry System)
	Avaya – Phone System
	Avaya CMS - Call Tracking
	CMS
	Compass21
	EDI – Claims Forwarding
	EDI – Claims Processing
	EDI – Eligibility
	EDI – Encounters
	EDI – EVV (Electronic Visit Verification)
	FTP – Non-EDI
	LTC On-line Portal
	MedNeedy
	MEHIS Claims History - Oracle HTB/HIEOS
	OFL (On-line Fee-schedule Lookup)
	OPL (On-line Provider Lookup)/PIMS (Provider Information Management System)
	PA on the Portal
	PA Workflow
	PEP (Provider Enrollment on the Portal)
	Portal – EVV (Electronic Visit Verification)
	Portal – MyAccount
	Portal – TMHP.com (include required SharePoint functionality)
	Portal – Provider Workshop
	Provider Incentive Payments
	TexMedConnect Claims
	TexMedConnect Eligibility
	Right Fax

EXHIBIT B
Attachment 40
Systems Application Inventory

Availability Operating	TMMIS system
Priority 2 13x7 7am - 8pm daily	Automated Call Recording (Verint)
	eOPM (Electronic Operational Procedures Manual)
	EPC (Expedited Plan Code)
	Firebird
	JIP (Joint Interface Plan)
	Mass Adjustments on the Portal
	Microsoft Dynamics CRM
	OnBase – Reporting
	Phoenix
	PPM
	PSWin
	SharePoint Document Management
	TPL – Recovery (RATS, HATS, CATS, DARTS, ICD)
	TPL - Health Insurance Premium Payment (HIPP)/ Insurance Premium
	VPN

Availability Operating	TMMIS system
Priority 3 13x5 7am - 8pm Mon - Fri	BusinessObjects
	Data Warehouse
	Encounters Data Warehouse
	EDW Staging Environment
	LTC Online Portal Reporting Database
	Medicaid/CHIP Data Analytics (MCAD) Platform Infrastructure software*
	* The Medicaid/CHIP Data Analytics Platform will have after-

EXHIBIT B
Attachment 40
Systems Application Inventory

System	System Description
TMMIS	The Texas Medicaid Management Information System (TMMIS) is an integrated group of systems designed to support Federal and State run Medicaid programs. The objectives of this system and its enhancements include program control and administrative costs for State and Federal managed Medicaid programs; service to recipients; provider authorizations, payments and inquiries; operations of claims control and processing capabilities; and management reporting for planning and control.

System	System Description	Vendor Support
Automated Call Recording (Verint)	System used to record all calls that reach a live Texas Medicaid agent.	
AIS (Automated Inquiry System)	Phone voice response system that provides information including client eligibility claims payments, claims status, benefit limitations, check amounts, and fax back capabilities.	
Avaya - Phone System	Telephone system that routes calls through the phone switch to appropriate call center staff. System integrates with the Microsoft CRM system for call tracking.	
Avaya CMS – Call Tracking	The Avaya Call Management System (CMS) monitors the phone switch for the Texas Medicaid Contact Center and collects data such as caller and agent identification, service parameters, call transfers, and call times. Contact Center administrators can then use the Avaya CMS Supervisor software to generate various reports that help them analyze and manage the efficiency of the Contact Center.	
Business Objects	Data analytic reporting platform for the data warehouses. The tool provides capability for standard reports and adhoc query capability. The content is aggregated into reporting universes.	

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Systems Application Inventory

System	System Description	Vendor Support
CMS	The Claims Management System (CMS) processes long-term care claims for Long Term Care state programs.	
Compass21	A core system for the Texas Medicaid program. Functions include claim processing, cash financial processing, provider enrollment, prior authorizations, third party liability processing, and client eligibility for claims processing.	iHealth - NCCI Optum - BCS claim forwarding
Data Warehouse	Texas Medicaid data warehouse also known as the Vision21 platform. Data is extracted from the Compass21 system weekly and grouped into defined data marts.	
EDI – Claims Forwarding	System that submits acute and long term care claim transactions to Managed Care Organizations on behalf of Medicaid providers.	
EDI – Claims Processing	System that processes standardized healthcare transactions for claim and authorization requests. The claim requests are submitted in an X12 format, and the formats include the claim transaction for Professional, Institutional, Dental claim types (837), the claim status inquiry (276) and response (277), and claim remittance (835). Authorization requests are submitted through the (278) transaction type.	eviCore- Process Radiology PA via 278 transaction
EDI – Eligibility	System that processes standardized healthcare transactions for client eligibility inquiry requests. The eligibility requests are submitted in an X12 format, and the formats include the inbound eligibility Inquiry (270) and the eligibility inquiry response (271) transaction types. EDI eligibility provides real-time inquiry capability for participants in the Value Added Network (VAN) program and the MEHIS program.	

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Systems Application Inventory

System	System Description	Vendor Support
EDI – Encounters	System that processes batch claim transactions in an X12, 837 format. System feeds claim data into the Encounter Data Operational Data Store which is the staging repository that stores Texas Managed Care Encounter claims data from the EDI Encounter System.	
EDI – EVV (Electronic Visit Verification)	System that processes visit data from EVV Vendors. EVV Vendors submit an EDI proprietary file format transaction including both Visit and Invoice data. Accenture performs edits on the files, sends a response to the Vendor and stores the data in the Operational Data Store (ODS).	State approved EVV Vendors
EDW Staging Environment	Database environment that includes replicated data from select Texas Medicaid source systems to support data feeds to the HHSC Enterprise Data Warehouse (EDW) solution. This environment is accessible by the HHSC EDW team (and their authorized vendor) for running queries and extracts.	
Encounters Data Warehouse	Data warehouse platform that stores and aggregates Texas Encounter data. Encounter data is submitted to the Texas Medicaid program from Texas Managed Care and Transportation Organizations, and the data is loaded weekly into the warehouse.	
eOPM (Electronic Operational Procedures Manual)	Electronic Operational Procedures Manual (eOPM). Tool to search and access operational process and procedure documentation online.	
EPC (Expedited Plan Code)	Expedited Plan Code on the Portal (EPC). Tool to create and manage plan codes and benefit plan data across multiple systems.	

EXHIBIT B
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Systems Application Inventory

System	System Description	Vendor Support
Firebird	Internal portal application used by Texas Medicaid staff to track provider complaints and fair hearings, High Cost DME equipment, provider outreach activities, hospital cost settlement, and manage provider workshop sessions.	
FTP – Non-EDI	System that is used to complete internal and external file transfers between Texas Medicaid and state approved trading partners.	
JIP (Joint Interface Plan)	Joint Interface Partner (JIP) Repository . Library of interface file layouts and metadata for files exchanged with external entities.	
LTC On-line Portal	Secure portal system that allows users to submit clinical assessment and authorization forms in support of Long Term Care programs.	
LTC Online Portal Reporting Database	Reporting platform of clinical assessment and authorization form data.	
Mass Adjustments on the Portal	Tool to create and execute online requests for a Claim Mass Adjustment, Claim Rate Change, or Claim Data Correction. Authorized users may define search criteria, execute sample and full runs, create reports to validate and document results.	
MedNeedy	Client server system that is to process client medical bills that can be applied to the required spend-down amount. Medically Needy is a qualification process that allows Texas HHSC applicants to receive Medicaid eligibility even though their family income exceeds the Medically Needy Income Limit (MNIL). The system runs on the Compass21 platform.	

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Systems Application Inventory

System	System Description	Vendor Support
Medicaid/CHIP Data Analytics (MCDA) Platform	Suite of data analytics developer tools hosted by Accenture for use by the Texas HHSC Medicaid/CHIP Data Analytics (MCDA) team and their authorized users. The platform includes MCDA software (*e.g.*, Tableau, SAS, ArcGIS, Oracle, etc.) as well as a Citrix environment that provides users with a virtual desktop for accessing all of their data analytics tools.	
Microsoft Dynamics CRM	Microsoft portal application that is used by Texas Medicaid staff to capture provider and client call and inquiry information.	Language Select - Provide interpretation services for call center staff
OFL (On-line Fee-schedule Lookup)	Secure portal application that allows providers to view claim payment fee information.	
OnBase - Reporting	Internal repository for Texas Medicaid reports	
OPL (On-line Provider Lookup)/ (PIMS) Provider Information Management System	Portal system that allows external users to lookup Texas Medicaid provider information. System also enables provides to complete demographic updates.	
MEHIS Claims History - Oracle HTB/HIEOS	Data repositories designed to provide standardized results for electronic health record exchange. The repositories support transactions for the Medicaid Eligibility Health Information Services (MEHIS) program.	
PA on the Portal	Secure portal system that allows online submission of prior authorizations (PA) requests and provides view capability for authorization status.	
PA Workflow	Portal application used internally by Texas Medicaid staff to process authorization requests.	

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Systems Application Inventory

System	System Description	Vendor Support
PEP (Provider Enrollment on the Portal)	Secure portal system that allows providers to complete Texas Medicaid enrollments and verify enrollment status. The system is used by internal Texas Medicaid staff to complete provider enrollment requests and perform provider record maintenance.	NocPlace - External service used to validate provider content during the enrollment process including provider exclusion and sanction reviews.
Phoenix	Internal client server system used by Texas Medicaid and state staff to perform business functions in the Compass21 system. Business functions include claim adjudication, provider enrollment, prior authorization, reference file maintenance, cash financial, third party liability, and client eligibility and claim view capability.	
Portal – EVV (Electronic Visit Verification)	Portal application that allows entry of Provider Selection Form (PSF) data submitted by providers and stored in the Operational Data Store (ODS).	
Portal – Provider Workshop	Secure portal application that allows users to register for Texas Medicaid educational workshops.	
Portal – MyAccount	Secure portal application allowing external providers and designees to manage portal security and navigate to Texas Medicaid portal systems.	
Portal - TMHP.com	Website for the Texas Medicaid program. Users can navigate to Medicaid content or login to secure portal applications through the site.	
PPM	Project & Portfolio Management is an internal portal application that is used to track risk and issue management, time management, operational and technology service requests, and provides workflow for some designated business functions.	

EXHIBIT B
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Systems Application Inventory

System	System Description	Vendor Support
Provider Incentive Payments	Secure portal site that allows provider to enlist in a state incentive plan for electronic health records.	CGI - Manage incentive enrollments for the EHR program.
PSWin	Provider Support Windows (PSWin) is a client server application that is used by Texas Medicaid and state staff to update references tables and view content in support of the Long Term Care program. The system views and updates content on the CMS system.	
RightFax	System used by Texas Medicaid staff to send and receive facsimile documentation in support of business functions.	
SharePoint Document Management	Portal repository for internal documents in support of the Texas Medicaid program.	
TexMedConnect Claims	Secure portal application that allows providers to submit claims in an interactive or batch mode for acute care and long term claim processing. Users can view claims statuses.	
TexMedConnect Eligibility	Secure portal application that allows providers to submit eligibility inquiries in an interactive or batch mode for acute care and long term clients.	

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Systems Application Inventory

System	System Description	Vendor Support
TPL - Health Insurance Premium Payment (HIPP)/ Insurance Premium Payment Assistance (IPPA) (PIER, MBIC, Fax Line, correspondence scanning and indexing software)	HIPP - System that determines cost-effectiveness for Medicaid programs and issues payment reimbursements to clients/employers/insurance companies for insurance premium payments IPPA - System that determines cost-effectiveness for the CSHCN program and issues payment reimbursements to clients/employers/insurance companies for insurance premium payments MBIC – Medicaid buy-in for children passthrough process between HMS and TIERS PIER – HIPP/IPPA case management tool Correspondence scanning and indexing software	HMS - Third Party Liability

EXHIBIT B
Attachment 40
Systems Application Inventory

System	System Description	Vendor Support
TPL - Recovery (RATS, HATS, CATS, DARTS, ICD)	**Referral Automated Tracking System (RATS)** – Tracks all TPR Other Insurance referrals, queues work to employees, calculates the Days On Hand and produces inventory and production reports. **Cash Automated Tracking System (CATS)** – Tracks all Cash Receipts (TARS, Provider, State Warrant, Collection and MTP), queues work to employees, calculates the Days On Hand and produces inventory and production reports (including exception reports, missed report etc). **History Automated Tracking System (HATS)** – All claims paid for a third party liability case are loaded into HATS where the Tort Analyst are able to review each paid claim and select which claims are related to the date of accident. Produces an itemized list of all claims paid related to the accident and are shared auto insurance companies and/or attorneys. **Denials Automated Recovery Tracking System (DARTS)** – The TARS selection file and the payment file are loaded into DARTS and the work is queued up to the employees. Tracks claims until they are recovered or until they age out and provides inventory and production reports. **Informational Claims Database** - The Informational Claims Database tracks all informational claims from the time it is received to the time it is either archived, paid or denied. Tracks and reports on number of informational claims that were received (accepted or rejected), conversion requests (accepted or rejected), archived, paid or denied monthly.	Conduent (formerly Xerox Recovery Services, Inc.)

EXHIBIT B
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Systems Application Inventory

System	System Description	Vendor Support
VPN	Client install that allows external approved submitters, state, and Texas Medicaid staff to access TMMIS systems outside the vendor location.	

EXHIBIT B
Attachment 41
Technology Infrastructure Inventory

The Services will include the management of the infrastructure set forth in the spreadsheet designated as "Quarterly Capital Items Report" described in Section 6 of Exhibit C, as may be updated by the Parties from time to time by mutual agreement.

EXHIBIT B
Attachment 42
Priority One Interfaces Inventory

The file titled "EXHIBIT_B_ATTACHMENT42.xlsx" is incorporated by reference herein as if set forth fully herein. The Parties may update this file from time to time as a matter of course without the need for a formal Amendment or Minor Administrative Change.

EXHIBIT B
Attachment 43
Deliverables

The following document or report deliverables ("Deliverables") will be produced by the Contractor. Refer to the TMMIS Contract Takeover Transition Guidelines document in the Procurement Library for deliverables that must be updated by the Contractor during the Transition Phase. Refer to Section 8 of the RFP for requirements of deliverables listed below. This preliminary list may be added, subtracted or otherwise modified as agreed to by HHSC and the Contractor:

Deliverable Name	Description
Six Month Evaluation Report	Conduct a six-month evaluation report of the Annual Business Plan and submit within timeframes specified by the State.
Annual Business Plan	Develop an Annual Business Plan and submit to the State for approval sixty (60) calendar days prior to the beginning of each SFY, with content, and in a media and format approved by the State.
Annual Provider Recruitment and Retention Plan	Submit an Annual Provider Recruitment and Retention Plan to the State in accordance with State-approved content, format and schedule.
Annual Provider Training Plan	Develop for State approval an Annual Provider Training Plan with content and in a media and format approved by the State.
Business Continuity and Contingency (BCC) Plan	Prepare and submit for State approval, a comprehensive Business Continuity and Contingency Plan (BCCP) on an annual basis, including an asset management process.
Disaster Recovery Plan	The Disaster Recovery (DR) Plan directs the recovery of critical business operations in the event of a disaster. This plan contains detailed procedures to recover Texas Medicaid Technical and Operational services that are instituted based on severity and stage of the disaster.
Processes and Procedures	The Process and Procedures (P&P) is documentation that defines a process from beginning to end regardless of department boundaries.
Quality Management Plan	Develop and maintain a Quality Management Plan in a content, media, and format approved by the State. Submit the Quality Management Plan to the State for approval within timeframes agreed upon with the State. The Quality Management Plan scope must include all areas of the Contract and State-approved methodologies for measuring quality.

EXHIBIT B
Attachment 43
Deliverables

Deliverable Name	Description
Reports - Enterprise	Produce, maintain and deliver Monthly Quality Assurance Reports for the Enterprise Reports Deliverable as agreed to by the State. These reports are generated based on contract requirements set forth in the Enterprise Reports Deliverable. These reports have standard delivery timeframes including weekly, monthly, quarterly and annually.
Reports - Key Measures	Produce, maintain and deliver a Key Measures Report Deliverable providing actual data against the Key Measures that are measured on a monthly basis or measured in the applicable month as agreed to by the State.
Reports - Operations	Produce, maintain and deliver the Operations Reports Deliverable as agreed to by the State. This deliverable should include the Annual Accounts Receivable Balance report and other reports that have been identified by the State.
Data Security Plan	Develop and submit a Data Security Plan to the State for approval, within six (6) months after Contract signing. The Data Security Plan must comply with current State-approved processes and procedures and include encryption of Protected Health Information (PHI) and Confidential Information, and a plan for notifying the State of security violations.
Physical Security Plan	Develop and submit for State approval the Physical Security Plan, within six (6) months after Contract signing. The Physical Security Plan is to be for the primary Contractor facility and each off-site facility, including storage facilities and security guards, within media, format and content approved by the State.
Staff Training Plan	Staff Training Plan pertains to Contractor and HHSC training. For Provider Training, reference the Annual Provider Training Plan. Produce a Staff Training Plan Deliverable for Contractor staff and State staff. The Staff Training Plan Deliverable should include but not limited to: TMMIS automated systems, functionality, procedures, processes, interfaces, etc.

EXHIBIT B
Attachment 43
Deliverables

Deliverable Name	Description
Turnover Plan	The Turnover Plan details the proposed schedule, activities, and resource requirements associated with turnover tasks and to ensure that clients and program stakeholders do not experience any adverse impact from the transfer of all State program data from Contractor to either the State or a successor contractor. Submit a Turnover Plan within timeframes, format, content, and media approved by the State.

EXHIBIT B
Attachment 44
Key Measure Implementation

The Key Measures require changes prior to reporting. CONTRACTOR has estimated the work effort for these changes required above the efforts included in Exhibit D. The table reflects the work effort to be completed as part of the Transition phase. HHSC and CONTRACTOR, unless otherwise noted in Attachment 37, agree the following Key Measures will be effective on the Operational Start Date. For avoidance of doubt, for the items below designated as "0 Hours", the expected level of effort need to make the applicable change is di minimus and will be implemented as part of Transition.

Key Measure #	Effort Description	Estimated Work Effort
ACR - 0009	Effort planned in transition period	0 Hours
ACR - 0026	Operational and technology changes required for measuring and reporting.	1300 Hours covered via base enhancements or as elected by the State.
CPC - 0054	The work to develop reporting for this KM will be estimated after definition of the calculation method is complete. Any implementation of this requirement is subject to the requirements of Article 9 of this Agreement.	To be determined.
CPC - 0121	Operational and technology changes required for measuring and reporting.	100 Hours to be performed by CONTRACTOR as part of Transition
CPC - 0130	Operational and technology changes required for measuring and reporting.	500 Hours to be performed by CONTRACTOR as part of Transition
GOC - 0239	Effort planned in transition period	0 Hours
MDP - 0072	Effort planned in transition period	0 Hours
PAC - 0052	Effort planned in transition period	0 Hours

EXHIBIT B
Attachment 44
Key Measure Implementation

Key Measure #	Effort Description	Estimated Work Effort
PAC - 0093	Effort planned in transition period	0 Hours
PRV - 0089	The work to develop reporting for this KM will be estimated after definition of the calculation method is complete. Any implementation of this requirement is subject to the requirements of Article 9 of this Agreement.	To be determined.
PRV – 0407	Effort planned in transition period	0 Hours

EXHIBIT C

Exhibit C: Financial Terms

This Exhibit C and its attachments detail the financial and payment provisions applicable to CONTRACTOR's performance of its obligations pursuant to the terms and condition of this Agreement. Payment for the Services and production of the Deliverables will be based on several pricing structures, depending on the specific Service required. The following sections further describe the components of each pricing structure to be utilized by HHSC and the major variables affecting each of them.

1. Payments for Transition Services

HHSC will pay CONTRACTOR a transition/implementation Fee based on successful completion and acceptance by HHSC of each key milestone for the successful performance of the transition/implementation Services as set forth in Exhibit D-01. Transition costs in excess of the final fixed price amount(s) included in the Agreement will not be paid by HHSC.

Any costs incurred by CONTRACTOR after the Operational Start Date of a specific Key Milestone to complete transition activities or correct any defects from the Transition phase of that specific Key Milestone must not be recorded as an operational cost and will not be considered an Allowable Cost for the Retrospective Cost Settlement provision of this Agreement.

2. Payments for Operational Services

HHSC is paying the Fees to CONTRACTOR for Services in support of the programs listed in Exhibit D according to the Functional Requirements and Key Measures set forth in Exhibit B. CONTRACTOR agrees that the total sum of the Fees paid to CONTRACTOR for Operational Services will consist of the following:

a. The monthly Fixed Fees which are described as follows:

HHSC will pay CONTRACTOR a monthly Fixed Fee by program area as set forth in Exhibit D-02 for the successful performance of the Services and production of the Deliverables upon the commencement of Operational Contract Year One as defined in Section 3.04(c) of this Agreement. CONTRACTOR must submit invoices for each fixed administrative pricing program as required by Section 3 of this Exhibit C.

Base Enhancement Team Hours

A part of the Fixed Fees included in Exhibit D-02 represent payment for 115,200 hours per Operational Contract Year for technology modifications ("base enhancement team") to be performed by CONTRACTOR staff as directed by HHSC staff for modifications to the TMMIS. The Parties acknowledge and agree that any hours less than 5% of the 115,200 hours not provided in an Operational Contract Year may be performed in a subsequent year and will be in addition to previously allocated 115,200 hours. The Fees for the hours performed in addition to the required 115,200 hours in a subsequent year due to this provision will

increase the RCS Ceiling for purposes of the RCS and Productivity Share Determination process.

In the event the unused hours referenced in the preceding paragraph exceed 5%, CONTRACTOR, unless otherwise agreed by the Parties, will reduce any applicable invoices related to Fixed Fees by an amount equal to the product of the average hourly CONTRACTOR Rates for that Operational Contract Year times the number of hours below the required 115,200 hours that CONTRACTOR did not provide for technology modifications in an Operational Contract Year directed to be provided by HHSC. CONTRACTOR will not be required to provide any such reduction where a balance of the 115,200 hours is due to HHSC not directing CONTRACTOR to provide sufficient technology modifications to exhaust the 115,200 hours. Any reductions to invoices during an Operational Contract Year due to this provision will also reduce the RCS Ceiling for purposes of the RCS and Productivity Share Determination process.

A part of the Fixed Fees included on Exhibit D-02 represent payment for 23,040 hours for technology modifications ("base enhancement team") to be performed by CONTRACTOR staff as directed by HHSC staff for modifications to the TMMIS related specifically to LTC requirements in Exhibit "B" to this Agreement. The Parties acknowledge and agree that any hours less than 5% of the 23,040 hours not provided in an Operational Contract Year may be performed in a subsequent year and will be in addition to previously allocated 23,040 hours. The Fees for the hours performed in addition to the required 23,040 hours in a subsequent year due to this provision will increase the RCS Ceiling for purposes of the RCS and Productivity Share Determination process.

In the event the unused hours referenced in the preceding paragraph exceed 5%, CONTRACTOR, unless otherwise agreed by the Parties, will reduce any applicable invoices related to Fixed Fees by an amount equal to the product of the average hourly CONTRACTOR Rate for that Operational Contract Year times the number of hours below the required 23,040 hours that CONTRACTOR did not provide for technology modifications in an Operational Contract Year directed to be provided by HHSC. CONTRACTOR will not be required to provide any such reduction where a balance of the 23,040 hours is due to HHSC not directing CONTRACTOR to provide sufficient technology modifications to exhaust the 23,040 hours. Any reductions to invoices during an Operational Contract Year due to this provision will also reduce the RCS Ceiling for purposes of the RCS and Productivity Share Determination process.

b. The monthly Variable Baseline Fees (subject to the ARC/RRC process) described as follows:

A monthly variable baseline Fee will be charged for certain activities that have changing volumes ("Variable Baseline Fees"). Variable Baseline Fees shall be

invoiced as set forth in Exhibit D-03(a). The Variable Baseline Fee shall be subject to adjustment based on a Sustained Change in the volume of transactions received by the operations unit performing the Services. Any applicable adjustments to Fees will commence in the month after the occurrence of the Sustained Change and any additional Sustained Changes thereafter will be subject to this process. If there is a Sustained Change, the monthly payment is adjusted by the Additional Resource Charge/Reduced Resource Credit ("ARC/RRC") level and value as described in the applicable ARC/RRC tables in Exhibits D-03(b)(1), Exhibit D-03(b)(2), Exhibit D-03(b)(3), Exhibit D-03(b)(4), Exhibit D-03(b)(5), Exhibit D-03(b)(6). In such instances, the monthly payment will be adjusted by the lowest applicable ARC/RRC level. For clarification, a Sustained Change may overlap another Sustained Change. In the event that the Sustained Change occurs in the Reprice Threshold for a given function, the Parties will jointly perform a repricing exercise for such function to determine the equitable adjustment to the Fixed Fee and Variable Baseline Fee, the baseline volumes, the RCS Ceiling and the ARC/RRC levels and values for the Service affected. CONTRACTOR's monthly billing will reflect the impact of ARC/RRC price adjustments in the billing for the Service Month being invoiced. The following Figure 1 demonstrates examples of various ARC/RRC adjustment scenarios:

Texas Health and Human Services Commission
Claims Processing & Administration
HHSC Contract # 529-16-0007
ARC/RRC Scenarios
Exhibit "C" Figure 1

These scenarios are for illustration only and will not determine the actual ARC/RRC decisions.

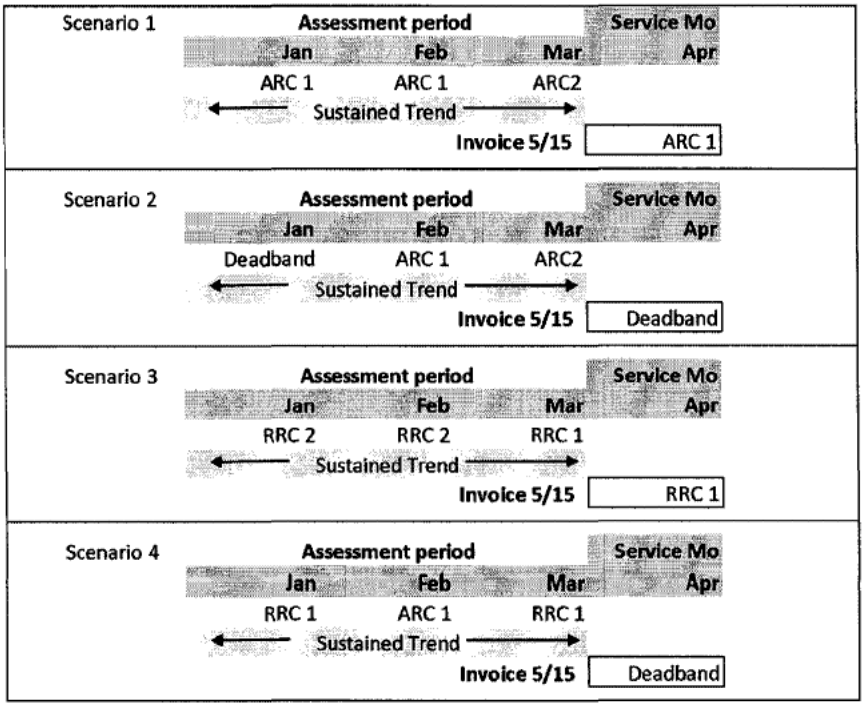


Figure 1: Example ARC/RRC Models

The following section describes the functions for which pricing will be adjusted to reflect Sustained Changes in volumes across the operations for contracted services.

The ARC/RRC categories are the following:

- Claims Processing
- Provider Call Center
- Client Call Center
- Long-Term Care
- Provider Enrollment
- Prior Authorization

ARC/RRC Volumes:

1. *Claims Processing Volumes*: Claims processing volumes are based upon the number of claims, regardless of submission source, requiring manual processing during a month. Manually processed claims are claims that suspend due to system edits and audits. The count per month will be based on the total number of edits and audits that are manually cleared from the suspension queues in the month. The total count will be measured by summing the total number of claims work queue items in all claims suspense work queues that were manually worked and cleared during a Service Month.

2. *Client Call Center Volumes:* Client Call Center - Client call center volume will be based upon the number of client calls handled by a call center agent in a given Service Month. A Client call is a call from a recipient that is received on one of the client call lines or the Medicaid call transfer line serviced by CONTRACTOR. The count shall be based upon the number of calls accepted by the IVR or ACD that are not abandoned or dropped prior to being handled by an agent. The lines for which calls will be counted for the purpose of measuring the monthly call volume for Client call center consist of:
    * Statewide Medicaid Helpline (Client English, Client Spanish, TWHP Eng, TWHP Sp)
    * Statewide Medicaid Helpline CSHCN (Client CSHCN Eng, Client CSHCN Sp)
    * Case Management (HCDME Eng, HCDME Sp, PCS Client)
    * Medicaid Call Transfer Line

3. *Long-Term Care Volumes:* Long-term care volumes will be based upon the number of assessments and evaluations reviewed during a Service Month, or "long-term care determinations and evaluations", plus the number of phone calls serviced by the LTC Contact Center.

Long-term care determinations and evaluations consist of:

* Medical necessity review of a provider submitted assessment of a client's condition, which may be authorized for long-term care services, and application of Level of Care guidelines (RUG) from CMS. These include PASRR evaluations, MDS assessments, and MNLOC assessments reviewed in a Billing Month as recorded in the Long-Term Care Portal.
* Medical Necessity evaluations of Custom Power Wheel Chairs.
* Screening and Assessment Instrument (SK-SAI Form) to identify the presence of skilled needs and interventions in order to determine the medical necessity of services.

4. *Provider Call Volumes:* Provider call volumes will be based upon the number of provider calls handled by a call center agent in a given Service Month, which consist of a call from a provider that is handled on one of the provider call lines serviced by CONTRACTOR. The count shall be based upon the number of calls accepted by the IVR that are not abandoned or dropped prior to being handled by an agent. The lines for which calls will be counted for the purpose of measuring the monthly call volume for Provider Calls consist of:
    * Provider (Provider Queue 1, TWHP Provider, Ambulance, Appeals, Provider Enrollment, Provider Queue 2)
    * THSteps Dental
    * THSteps Medical
    * CSHCN (CSHCN)
    * EDI Helpdesk (EDI Helpdesk)

    For clarity, LTC Call Center volumes are excluded from this ARC/RRC.

5. *Prior Authorization Volumes:* The volume of work completed in a given month for Prior Authorization Services is defined as the Prior Authorizations closed per Month. Prior Authorizations closed per month shall be calculated as the number of PA requests that are recorded in the following statuses in the CURRENT STATUS field in the PA Workflow System with a value in the CLOSED DATE field within the Service Month:
    * Closed Duplicate
    * Closed Matched
    * Closed No Match
    * PA Complete Closed
    * Closed Pending Fair Hearing
    * Closed Fair Hearing Complete

    The status that will be evaluated is the CURRENT STATUS field in the PA Workflow system. The date that will be evaluated is the CLOSED DATE field in the PA Workflow system. A PA Request will be identified as a unique PORTAL ID in the PA Workflow system.

6. *Provider Enrollment Volumes:* Provider Enrollment volume will be based upon the total provider data management work items processed by the CONTRACTOR Provider Enrollment team in a given Service Month. Provider data management work items are any item processed by CONTRACTOR whether received on paper or electronically to enroll or maintain a provider's data in the TMMIS.

   These items include Provider Enrollments, Provider Re Enrollments, Provider Validations, File Maintenance Requests, Deficiency Letter Responses, and Site Visits.

   The volume shall be based on a count of the number of unique provider counts on the provider applications, provider re enrollments, provider file maintenance requests, provider deficiency letter responses, and site visits processed in the Service Month as recorded in PPM (Provider Enrollment Workflow). Unique providers would be each TPI/Suffix on the application. This would be counted based on a query done between PPM and PEP (Provider Enrollment on Portal). The volume will be based on the number of applications processed by CONTRACTOR (both paper applications & electronic applications), not necessarily based on number of providers rendered.

The Parties acknowledge that the volumes for the Provider Enrollment ARC/RRC are not readily predictable and that the baseline for Provider Enrollment is difficult to establish with a high degree of confidence as of the Effective Date. The Parties also acknowledge that the staffing level and costs for the Provider Enrollment function are based upon the definition and baseline volume that is stated in the Agreement. Therefore, the Parties agree to review the Provider Enrollment volumes as measured according to the ARC/RRC definitions herein for the first six (6) months from the Operations Start Date and determine if an adjustment to the baseline and/or associated cost is warranted.

c. The monthly Variable Unit Rate Fees described as follows:

Variable Unit Rate Fees will be calculated by multiplying the applicable CONTRACTOR Unit Rates (associated with Subcontractor functions) times the actual units incurred and further described as follows:

The following Services provided by Subcontractors will be billed on a per-unit basis as specified in Exhibit D-03(c):

- Front-End Services (SourceHOV)
  - The following section provides further details on the types of units that will be processed and billed for Front-End Services.
- Letter Translation Services (Albornoz & Associates)
  - Albornoz & Associates will translate Medicaid Service Denial Letters

from English into Spanish.

- Foreign Language Call Handling (Language Select)
  - Language Select will provide services to translate Spanish calls and will provide services to translate non-Spanish calls.
- Radiology Prior Authorization (eviCore Healthcare)
  - eviCore Healthcare, formerly MedSolutions, SHC, will disposition prior authorizations of radiology services.

Front-End Services

"Front End Services" are those Services provided for mailroom operations, data entry, and image scanning and storage functions. Mailroom and data entry services generally include receiving incoming documents from the United States Postal Service, other private carriers, email and file transmissions. Documents received are validated, scanned, and routed for data entry and other processing. The following tables describe the documents within the scope of Front End Services:

Description	Unit
Front End Conversion	
Onsite Mailroom – Intake (Paper)	Per Image (double sided page =2 images)
Onsite Mailroom – Intake (Electronic)	Per Image
X-ray Intake	Per x-ray
Data Capture	
CMS1500 Single/ Claim Adjustments - All	Per Document
CMS1500 Multi	Per Document
CMS1500 Crossover	Per Document
CMS Advantage	Per Document
UB04 Single	Per Document
UB04 Multi	Per Document
UB04 Crossovers	Per Document
UB04 Advantage	Per Document
Dental Single	Per Document
Dental Multi	Per Document
Family Planning	Per Document
Correspondence Single / Multi	Per Document
Claims Adjustment	Per Document
RTP Single	Per Document
RTP Multi	Per Document
TPL Single	Per Document
TPL Multi	Per Document
Bad Address Indexing	Per Return Mail
SUR Documentation	Per Document
Check Processing	
Check Indexing/Email	Per Document
Check image scanning into JPMC via website	Per Image
Unacceptable Payee Check Return	Per Document

The "Correspondence Single/Multi" category in the Projected Monthly Volumes table above includes the document types listed below:

#	Category Type	Form Type
1	PA - Prior Authorization	Ambulance
2	PA - Prior Authorization	CCP
3	PA - Prior Authorization	CCIP
4	PA - Prior Authorization	CSHCN
5	PA - Prior Authorization	SMPA - Special Med Prior Auth
6	PA - Prior Authorization	Dental
7	PA - Prior Authorization	Home Health
8	PA - Prior Authorization	Nursing Facilities
9	PA - Prior Authorization	Concurrent Review
10	PA - Prior Authorization	Family Planning
11	PA - Prior Authorization	DME
12	Provider	Provider Correspondence
13	Provider	Provider Credentialing
14	Provider	Provider Enrollment
15	Provider	Provider Services
16	Provider	Complaints & Appeals
17	Provider	EDI R&S
18	Provider	EDI Fax
19	Provider	Claims - Hyster Ack Forms/Dental
20	Provider	SUR
21	Other	1039
22	Other	SAR
23	Other	TXMED
24	Other	Funds Management
25	Other	MED Needy
26	Other	HHSC
27	Other	Client Correspondence
28	Other	Client Services

d. Pass-Through Expenses described as follows:

Except for procurement of capital items pursuant to Section 6 of this Exhibit C, actual expenditures for Pass-Through Expenses made on the HHSC's behalf will be paid without allocation of any Predetermined Rates. Pass-Through Expenses specifically related to capital expenditures, software license and maintenance fees will only be billed by CONTRACTOR and paid after CONTRACTOR actually incurs the Pass-Through Expense.

The Parties agree that a listing of expenditures that will be designated as Pass-Through Expenses is as follows:

1) Capital expenditures approved pursuant to Section 6 of this Exhibit C, including the applicable mark-up on such purchases;
2) All postage/delivery costs directly related to the operation of the Agreement;
3) Software license & maintenance fees;
4) Office rent (including lease pass-through expenses);
5) All printing costs including provider manuals, handbooks, bulletins, and similar;
6) All telecommunication lines, including local lines, toll-free lines, electronic communications lines, fiber optic lines, cell phones, Internet connections, etc.; and
7) Payments made by CONTRACTOR to EVV vendors.

e. The Contingency Fees for collection of Third Party Resources described as follows:

As further described in the Statement of Work, CONTRACTOR will perform Services related to the collection of funds from Third Party Resources for Medicaid and CSHCN claims that have been paid by the State of Texas. The Third Party Resource payments will be paid in accordance with Exhibit D-06.

f. Predecessor Contract Amendment Fees

Fees for Services performed by CONTRACTOR for Amendments executed prior to the Effective Date but not completed under the predecessor contract #529-14-0125-00003 between HHSC and CONTRACTOR. Predecessor Contract Amendment Fees will be paid in accordance with Exhibit D-05, as may be amended.

3. Invoices

a. General Requirements

CONTRACTOR acknowledges and agrees to provide supporting documentation for all invoices, in an electronic format, subject to approval by each State Agency, by Program, by Amendment, appropriations strategy, risk group, and Federal Financial Participation (FFP) rate.

b. Submission Requirements

Invoices must be:

1. In writing;

2. Completed to the degree specified in this Agreement; and

3. Submitted to the individual or department specified by HHSC or to the appropriate State agency no earlier than the 1st day of the month following the month in which Services were performed; but, no later than the 15th day of the month following the month in which Services were performed. Failure to deliver an invoice in the specified timeframe will not constitute a waiver by CONTRACTOR of its right to receive payment for such invoice.

4. Upon HHSC request and subject to Section 6.05 of this Agreement, CONTRACTOR will provide any additional information to the degree of detail necessary to resolve any review, examination, inquiry or audit by HHSC or any other responsible authority.

In addition:

5. CONTRACTOR uses a separate State Purchase Voucher and Invoice for each program including details on the federal funding allocation.

6. CONTRACTOR allocates the detailed pricing exhibit category to an Activity Description. CONTRACTOR then allocates activities to the appropriate program based on the State's direction.

7. CONTRACTOR bills the monthly Fees for any Amendments and the Contingency Fees using a separate Pricing Voucher and CONTRACTOR invoice for each.

c. Time and Manner of Payment

Payment of each invoice submitted by CONTRACTOR under this Agreement will be made in accordance with Section 6.02 of the Agreement.

4. Systems Maintenance, Modifications, and Additional Periodic Activities

HHSC anticipates that, during the life of the Agreement, implementation of State and/or federal mandates and other State initiatives will require additions or changes to the activities performed under this Agreement. Payment for Fees associated with changes to Services and/or Deliverables required after the Effective Date will be negotiated with the CONTRACTOR. The CONTRACTOR will develop not to exceed fixed price change order responses based on the performance requirements and the specified results included in any potential change order requested by HHSC. The not to exceed change order will utilize the CONTRACTOR Rates described by Exhibit D-04.

The CONTRACTOR Rates contain all labor costs related to performing the required functions; including, but not limited to, Predetermined Rates. No additional costs will be paid for any other items unless the Parties agree that any additional cost(s) requested by

the Contractor are unique to the specific project and that the CONTRACTOR should not have otherwise included those additional costs as part of the CONTRACTOR Rates. The pricing for additional costs associated with periodic activities will be negotiated between the CONTRACTOR and HHSC based on CONTRACTOR's submission of sufficient financial justification (including detailed metrics) to add additional Fees to the CONTRACTOR Rates.

5. **Additional Recurring Activity Charges**
HHSC anticipates that, during the life of the Agreement, implementation of State and federal mandates and other State initiatives will require additions or changes to the normal activities performed under the Agreement. All such changes will be negotiated between HHSC and CONTRACTOR. The pricing associated with additional recurring activities will be negotiated between the CONTRACTOR and HHSC based on the CONTRACTOR Rates and submission of sufficient financial justification (including detailed metrics). Once a total cost for the additional recurring activities is agreed upon, HHSC will make the determination as to whether the fixed fee formula(s) are modified, one or more of the variable formula(s) are modified, or all appropriate administrative payment components are modified.

   The fixed annual inflation/deflation factor(s) and the Predetermined Rates will be applicable for any of the proposed costs submitted by the CONTRACTOR and reviewed by HHSC to determine the appropriate fixed and/or variable fee adjustments included in any amendment executed to include the additional recurring activities under the Agreement.

6. **Ownership of Capital Items at Termination of the Contract**
As further described herein, CONTRACTOR may act as the agent of HHSC to procure nonexpendable capital items needed for this Agreement as a Pass Through Expense. Upon delivery and receipt of the invoice from seller, CONTRACTOR will invoice HHSC for the applicable capital items in the invoice applicable to that Service Month. HHSC will assume ownership or license rights, as applicable, of capital equipment and other items procured by CONTRACTOR on HHSC's behalf immediately upon transfer of title by the seller. Any sale of such capital equipment or items will be a sale by the seller to HHSC, and not to CONTRACTOR. CONTRACTOR will obtain no ownership interest in nor accept title to any such equipment or software items. CONTRACTOR, at HHSC's direction, may engage a third party to hold software licenses on behalf of HHSC. In such cases the licenses may be transferred to HHSC upon request or upon Agreement termination.

   Nonexpendable capital items are defined as tangible and personal property or software, procured by CONTRACTOR on behalf of HHSC, of a non-consumable nature that have an acquisition cost of $500.00 or more per unit and an expected useful life of at least one year. The term nonexpendable capital item includes, but is not limited to, office furniture, office equipment, telephone equipment, computer furniture, computer equipment, computer software (including commercially off the shelf (COTS) software) and computer leases. CONTRACTOR will not unreasonably restrict HHSC's access to the

nonexpendable capital items, so long as such access does not interfere with the performance of the Services.

At HHSC's direction, CONTRACTOR will ship all nonexpendable capital items purchased and third party software licensed pursuant to the Agreement, freight prepaid, Freight On Board (FOB) HHSC's destination. The method of shipment will be consistent with the nature of the nonexpendable capital items and hazards of transportation. Regardless of FOB point, the HHSC will bear all risks of loss, damage, or destruction of Deliverables, in whole or in part, ordered hereunder that occurs prior to acceptance by HHSC, except loss or damage attributable to the CONTRACTOR's fault or negligence.

CONTRACTOR is advised not to enter into any leases that extend beyond the Initial Term. In no event will HHSC reimburse the CONTRACTOR for the portion of any lease that is allocable beyond the Initial Term, unless the Parties have opted to extend the Agreement.

All nonexpendable capital items acquired under this Agreement will be recorded and a list will be provided to HHSC at the end of each state fiscal quarter. The CONTRACTOR will use an asset tracking system, processes, procedures, and asset tracking software approved by HHSC to record all nonexpendable capital items on the required asset list. The list of the nonexpendable capital items will include the following information, at a minimum:

- A description of each capital item;
- Model number;
- Manufacturer's serial number where applicable;
- Funding source;
- Information needed to calculate the federal and state share of the acquisition cost;
- Date of acquisition;
- Unit cost; and
- Information on the specific location of the capital item.

HHSC reserves the right to modify the detailed information necessary that is related to this asset listing requirement.

CONTRACTOR will obtain prior approval from HHSC before purchasing any nonexpendable capital equipment items and/or any commercially off the shelf software for this Agreement. CONTRACTOR may expend up to $50,000 from the capital equipment budget without obtaining prior approval to respond to an equipment malfunction that poses an immediate and serious threat to Agreement operations. CONTRACTOR must make every effort to contact HHSC staff prior to the acquisition of capital equipment to meet the emergent condition. CONTRACTOR must submit written documentation to HHSC within twenty-four (24) clock hours of discovering the emergent condition describing the emergent condition, efforts made to contact HHSC staff, actions taken to mitigate the emergent condition and a listing of any capital equipment purchased to resolve the emergent condition.

HHSC and CONTRACTOR acknowledge and agree that funds allocated for capital equipment procurement will not be used for any expenditure other than capital items (including but not limited to: capital equipment purchases, capital equipment leases or installation costs related to equipment, furniture, workstations, or other leasehold improvements) necessary to meet the requirements of this Agreement. HHSC and CONTRACTOR further acknowledge and agree that the capital equipment payments are separate and distinct from the Fees, and capital purchased will be invoiced as Pass-Through Expenses. Specifically for hardware and software purchases and maintenance, these Pass-Through Expenses may include a processing fee of up to 6%. The processing fee will be tiered based on the total DIR contract purchases each State fiscal year. The fee will be 6% for the initial $5 million of purchases in the fiscal year, with a reduction of 1% for every $3 million in spend with a floor of 3%:

- 6% up to $5 million fee ($300,000)
- 5% for $5 to $8 million – fee ($150,000)
- 4% for $8 to $11 million – fee ($120,000)
- 3% for $11 million+ fee (3% of any amount over $11M)

In the case of hardware and software items that are exempt from DIR contracts, the processing fee may not exceed 3%. This processing fee will not include any costs associated with hardware maintenance, or software license or maintenance, paid directly by HHSC to the applicable third party vendor.

7. **Retrospective Cost Settlement ("RCS") and Productivity Share Determination**
The following CONTRACTOR Fees and Pass-Through Expenses for each Operational Contract Year (collectively, the "RCS Ceiling") will be subject to the RCS and Productivity Share provisions described below:

- The Fixed Fees;
- The Variable Unit Fees;
- The Variable Baseline Fees related to ARC/RRC;
- Systems Maintenance and Modification Fees;
- Additional Recurring Activity Charges; and
- RCS Pass-Through Expenses, which consist of:
  1) All postage/delivery costs directly related to the operation of the Agreement;
  2) Office rent (including lease pass-through expenses);
  3) All printing costs including provider manuals, handbooks, bulletins, and similar;
  4) All telecommunication lines, including local lines, toll-free lines, electronic communications lines, fiber optic lines, cell phones, Internet connections, etc.; and
  5) Other Pass-Through Expenses agreed by the Parties.

All other CONTRACTOR Fees and costs will be excluded from the RCS and Productivity Share Determination provisions described below.

Adjustments to RCS Ceiling: CONTRACTOR and HHSC will review and adjust the RCS Ceiling to determine and distribute the amount of any applicable Productivity Share. RCS Ceiling will be reduced on a dollar for dollar basis for:

- Any cost determined not to be Reasonable. Upon determination that a cost is not Reasonable, and that such cost will not be Reasonable in subsequent Operational Contract Years: 1) CONTRACTOR will refund all Fees paid by HHSC for such costs, and 2) the Parties will amend Exhibit D: Payment Schedule as necessary to remove such Fees associated with such cost;
- Any cost determined to be unallowable through the RCS process described by Section 7(a) below; or
- Any CONTRACTOR labor cost reduction resulting in a CONTRACTOR failure to meet applicable Key Measures, where HHSC's imposition of remedies results in costs to CONTRACTOR less than the amount of the labor cost reduction. Only the CONTRACTOR labor cost reduction during the time period where the CONTRACTOR fails to meet applicable Key Measures will be subject to the RCS Ceiling reduction.

a. **Retrospective Cost Settlement**
The Retrospective Cost Settlement process will be conducted as follows:

1) *Annual Reporting Process:* No later than ninety (90) days after the expiration of each Operational Contract Year, or such period as has been mutually agreed upon by HHSC and the CONTRACTOR, the CONTRACTOR will submit to HHSC a report of the actual Allowable Costs (the "Annual Report") incurred by CONTRACTOR during such Operational Contract Year.

HHSC will review the Annual Report and, within sixty (60) days of receipt, notify CONTRACTOR of any issues or discrepancies requiring resolution. HHSC and CONTRACTOR will use reasonable efforts to resolve any such issues or discrepancies within ninety (90) days of HHSC's receipt of the Annual Report. Once complete, HHSC shall provide written notice to CONTRACTOR of its acceptance of the report. The date such notice is provided shall be the "Annual Report Acceptance Date." HHSC will not consider any additional Direct Costs after the Annual Report Acceptance Date.

2) *Tentative Productivity Share:* Using the information from the Annual Report as the tentative Approved Allowable Costs (as defined in Section 7(a)(3) below), the parties will determine whether there is a Cost Surplus or a Cost Shortfall using the process described by Section 7(b) below.

a) *Waiver of Cost Review:* Within fifteen (15) months of the Annual Report Acceptance Date, HHSC may waive the cost review by means of the Minor Administrative Change process. The decision to waive the cost review shall be deemed final and the tentative Approved Allowable Costs shall become the Approved Allowable Costs. In the event of a Cost Shortfall for an Operational Contact Year for which HHSC waives the cost review, CONTRACTOR shall pay to HHSC within sixty (60) days of receipt of HHSC's notice of such waiver the sum of all Productivity Discounts described by Section 7(b) below.

b) *HHSC Option to Receive Tentative Productivity Share:* In the event of a Cost Shortfall for an Operational Contact Year for which HHSC does not waive the cost review, HHSC shall have the option to either: 1) receive the tentative Productivity Discounts to which it may be entitled under Section 7(b) below; or 2) defer its receipt of such payment until after the cost review. HHSC shall notify CONTRACTOR of its decision on such option and in the event HHSC opts to receive such payment, CONTRACTOR shall within sixty (60) days of receipt of such notice pay HHSC the sum of all Productivity Discounts described by Section 7(b) below.

If HHSC has received a tentative Productivity Discount for an Operational Contract Year, any difference as a result of the RCS cost review for the same Operational Contract Year will be paid to or refunded by HHSC as applicable.

3) *Cost Review:* HHSC may conduct a cost review of the Allowable Costs included in the Annual Report pursuant to the Agreement. This cost review will be conducted by an independent third party unless otherwise agreed by the Parties, and will entail an evaluation of the actual Allowable Costs submitted by the CONTRACTOR. At the conclusion of this cost review, HHSC will determine the approved Allowable Costs ("Approved Allowable Costs") for the Operational Contract Year and will notify the CONTRACTOR with a full explanation of any exceptions it has taken to CONTRACTOR's Allowable Costs in the Annual Report. Unless otherwise agreed by the Parties, HHSC shall complete the cost review within fifteen (15) months of the Annual Report Acceptance Date.

Any determination made by HHSC regarding the Approved Allowable Costs will be final unless within 30 days from the receipt of the written notice to CONTRACTOR of such exceptions, the CONTRACTOR files a written objection with HHSC, which will be resolved in accordance with Section 8.15: Dispute Resolution of the Agreement. The resolution of any such disputes and HHSC's final determination of CONTRACTOR's Approved Allowable Costs for the Operational Contract year shall be documented in a closing agreement signed by HHSC and the CONTRACTOR.

b. **Productivity Share Determination**

Following the establishment of the Approved Allowable Costs, the Productivity Share Determination and distribution shall be conducted by comparing the RCS Ceiling will be compared against Approved Allowable Costs, resulting in one of the following:

1) *Approved Allowable Cost Surplus (or Neutral):* If, for the subject Operational Contract Year, the RCS Ceiling is less than or equal to the Approved Allowable Costs, the CONTRACTOR will accept the CONTRACTOR's Fees disbursed or otherwise payable to CONTRACTOR as payment in full for Services and Deliverables performed during the subject Operational Contract Year, and no further provisions of the RCS and Productivity Share Determination processes shall be pursued.

Any Approved Allowable Cost amounts not paid to CONTRACTOR due to their being in excess of the RCS Ceiling for an Operational Contract Year will not accrue or transfer to succeeding Operational Contract Years.

2) *Approved Allowable Cost Shortfall:* If the Approved Allowable Costs are less than the RCS Ceiling, the Parties will divide and share the amount of the difference (the "Cost Shortfall") as follows:

- *Tier 1 Productivity:* For the first 5% of Cost Shortfall, HHSC will receive 61% of the savings, while CONTRACTOR will retain 39% of the savings. The specific steps for sharing are:
  - The Cost Shortfall that represents the first 5% of savings will be multiplied by 61% resulting in the HHSC Tier 1 ("Productivity Discount").
  - The sum of the HHSC Tier 1 Productivity Discount and all costs determined to be unallowable as a result of the cost review will be paid by check to HHSC within 60 calendar days of such determination.
  - The Cost Shortfall that represents the first 5% of savings will be multiplied by 39% resulting in the CONTRACTOR Tier 1 ("Productivity Benefit").
  - The CONTRACTOR Tier 1 Productivity Benefit is not used for any further transactions, calculations, payments, or adjustments; it is merely the acknowledgement of CONTRACTOR's portion of the productivity share for a given Operational Contract Year which CONTRACTOR retains.

- *Tier 2 Productivity:* In the event savings exceed 5%, for the next 5% of savings (i.e., 5-10%), HHSC will receive 82% of the savings, while CONTRACTOR will retain 18% of the savings. The specific steps for sharing are:
  - The Cost Shortfall that represents 5-10% of savings will be multiplied by 82% resulting in the HHSC Tier 2 Productivity Discount.
  - The sum of the HHSC Tier 2 Productivity Discount and all costs determined to be unallowable as a result of the cost review will be paid by check to HHSC within 60 calendar days of such determination.
  - The Cost Shortfall that represents 5-10% of savings will be multiplied by 18% resulting in the CONTRACTOR Tier 2 Productivity Benefit.
  - The CONTRACTOR Tier 2 Productivity Benefit is not used for any further transactions, calculations, payments, or adjustments; it is merely the acknowledgement of CONTRACTOR's portion of the productivity share for a given Operational Contract Year which CONTRACTOR retains.

- *Tier 3 Productivity:* In the event of a Cost Shortfall greater than 10%, after processing both the HHSC Tier 1 and Tier 2 Productivity Discounts, the Parties will divide and distribute the Cost Shortfall amount exceeding 10% as mutually agreed. The specific steps for sharing are:
  - The Cost Shortfall that represents greater than 10% of savings will be multiplied by a percentage amount mutually agreed by the parties, resulting in the HHSC Tier 3 Productivity Discount.

- The sum of the HHSC Tier 3 Productivity Discount and all costs determined to be unallowable as a result of the cost review will be paid by check to HHSC within 60 calendar days of such determination.
- The Cost Shortfall that represents greater than 10% of savings will be multiplied by a percentage amount mutually agreed by the parties resulting in the CONTRACTOR Tier 3 Productivity Benefit.
- The CONTRACTOR Tier 3 Productivity Benefit is not used for any further transactions, calculations, payments, or adjustments; it is merely the acknowledgement of CONTRACTOR's portion of the Productivity Share for a given Operational Contract Year which CONTRACTOR retains.

Furthermore, the Parties agree to review factors materially impacting the Fees, Services and Deliverables, including but not limited to the use and application of the ARC/RRC structure. Following these reviews, the Parties may adjust the Services, Key Assumptions, Key Measures, Fees or other factors as necessary.

For purposes of illustration only, scenarios implementing the foregoing RCS and Productivity Share Determination processes are depicted in the following Figure 2:

Texas Health and Human Services Commission
Claims Processing & Administration
HHSC Contract # 529-16-0007
Productivity Share Determinations Scenarios and RCS Ceiling Adjustments
Exhibit "C" Figure 2

These scenarios are for purposes of illustration only and will not determine the actual RCS and Productivity Share dollar values.

Scenario 1: **Approved Allowable Costs are Under the original RCS Ceiling; triggers Tier 1 and Tier 2**		**Adjustment to RCS Ceiling and Refund All Unallowable Costs**	
RCS Ceiling (Actual Payments)	a	$ 200,000,000	
Annual Report of Allowable Costs	b	$ 189,680,000	
Approved Allowable Costs	c	$ 189,630,000	
Unallowable Costs (as determined by cost review)	d	$ 50,000	
Adjusted RCS Ceiling	e	$ 199,950,000	if d < 0, then a if c >= a, then a if c < a, then a-d if c >= e, then 0
"Cost Shortfall" amount subject to "Productivity Determinations"	f	$ 10,320,000	if c < e, then e-c
Total productivity % of Adjusted RCS Ceiling	g	5.2%	
Tier 1 "Productivity Discount" %	h	61%	
Total amount of "Cost Shortfall" subject to for "Tier 1 Productivity"	i	$ 9,997,500	if g <= 5%, then f else f * 5%
"Productivity Discount" Tier 1 funds due to HHSC	j	$ 6,098,475	h * i
Tier 2 "Productivity Discount" %	k	82%	
Total amount "Cost Shortfall" subject to for "Tier 2 Productivity"	l	$ 322,500	if g <= 10%, then f - i else f * 5%
"Productivity Discount" Tier 2 funds due to HHSC	m	$ 264,450	k * l
Tier 3 "Productivity Discount" %	n	TBD%	
Total amount "Cost Shortfall" subject to for "Tier 3 Productivity"	o	$ -	
"Productivity Discount" Tier 3 funds due to HHSC	p	TBD	
Total TIER 1, 2, & 3 funds due to HHSC for HHSC "Productivity Discount"	q	$ 6,362,925	j + m + p
Funds due to HHSC for Unallowable Costs (as determined in cost review)	r	$ 50,000	if d < 0, then 0 if c >= e, then 0 if c < e, then d
Total Net Paid by HHSC	s	**$ 193,587,075**	a - (q+r)

Scenario 2: **Approved Allowable Costs are Under the original RCS Ceiling; triggers Tier 1**		**Adjustment to RCS Ceiling and Refund All Unallowable Costs**	
RCS Ceiling (Actual Payments)	a	$ 200,000,000	
Annual Report of Allowable Costs	b	$ 198,000,000	
Approved Allowable Costs	c	$ 196,500,000	
Unallowable Costs (as determined by cost review)	d	$ 1,500,000	
Adjusted RCS Ceiling	e	$ 198,500,000	if d < 0, then a if c >= a, then a if c < a, then a-d if c >= e, then 0
"Cost Shortfall" amount subject to "Productivity Determinations"	f	$ 2,000,000	if c < e, then e-c
Total productivity % of Adjusted RCS Ceiling	g	1.0%	
Tier 1 "Productivity Discount" %	h	61%	
Total amount of "Cost Shortfall" subject to for "Tier 1 Productivity"	i	$ 2,000,000	if g <= 5%, then f else f * 5%
"Productivity Discount" Tier 1 funds due to HHSC	j	$ 1,220,000	h * i
Tier 2 "Productivity Discount" %	k	82%	
Total amount "Cost Shortfall" subject to for "Tier 2 Productivity"	l	$ -	if g <= 10%, then f - i else f * 5%
"Productivity Discount" Tier 2 funds due to HHSC	m	$ -	k * l
Tier 3 "Productivity Discount" %	n	TBD%	
Total amount "Cost Shortfall" subject to for "Tier 3 Productivity"	o	$ -	
"Productivity Discount" Tier 3 funds due to HHSC	p	TBD	
Total TIER 1, 2, & 3 funds due to HHSC for HHSC "Productivity Discount"	q	$ 1,220,000	j + m + p
Funds due to HHSC for Unallowable Costs (as determined in cost review)	r	$ 1,500,000	if d < 0, then 0 if c >= e, then 0 if c < e, then d
Total Net Paid by HHSC	s	**$ 197,280,000**	a - (q+r)

Figure 2: Example RCS and Productivity Share Models

Texas Health and Human Services Commission
Claims Processing & Administration
HHSC Contract # 529-16-0007
Productivity Share Determinations Scenarios and RCS Ceiling Adjustments
Exhibit "C" Figure 2

These scenarios are for purposes of illustration only and will not determine the actual RCS and Productivity Share dollar values.

Scenario 3: **Approved Allowable Costs are Under the original RCS Ceiling; but higher than reported.**		**Adjustment to RCS Ceiling and Refund All Unallowable Costs**	
RCS Ceiling (Actual Payments)	a	$ 200,000,000	
Annual Report of Allowable Costs	b	$ 198,000,000	
Approved Allowable Costs	c	$ 198,150,000	
Unallowable Costs (as determined by cost review)	d	$ (150,000)	
Adjusted RCS Ceiling	e	$ 200,000,000	if d < 0, then a if c >= a, then a if c < a, then a-d if c >= e, then 0
"Cost Shortfall" amount subject to "Productivity Determinations"	f	$ 1,850,000	if c < e, then e-c
Total productivity % of Adjusted RCS Ceiling	g	0.9%	
Tier 1 "Productivity Discount" %	h	61%	
Total amount of "Cost Shortfall" subject to for "Tier 1 Productivity"	i	$ 1,850,000	if g <= 5%, then f else f * 5%
"Productivity Discount" Tier 1 funds due to HHSC	j	$ 1,128,500	h * i
Tier 2 "Productivity Discount" %	k	82%	
Total amount "Cost Shortfall" subject to for "Tier 2 Productivity"	l	$ -	if g <= 10%, then f - i else f * 5%
"Productivity Discount" Tier 2 funds due to HHSC	m	$ -	k * l
Tier 3 "Productivity Discount" %	n	TBD%	
Total amount "Cost Shortfall" subject to for "Tier 3 Productivity"	o	$ -	
"Productivity Discount" Tier 3 funds due to HHSC	p	TBD	
Total TIER 1, 2, & 3 funds due to HHSC for HHSC "Productivity Discount"	q	$ 1,128,500	j + m + p
Funds due to HHSC for Unallowable Costs (as determined in cost review)	r	$ -	if d < 0, then 0 if c >= e, then 0 if c < e, then d
Total Net Paid by HHSC	s	**$ 198,871,500**	a - (q+r)

Scenario 4: **Approved Allowable Costs are Under the original RCS Ceiling; triggers Tier 3**		**Adjustment to RCS Ceiling and Refund All Unallowable Costs**	
RCS Ceiling (Actual Payments)	a	$ 200,000,000	
Annual Report of Allowable Costs	b	$ 175,680,000	
Approved Allowable Costs	c	$ 175,630,000	
Unallowable Costs (as determined by cost review)	d	$ 50,000	
Adjusted RCS Ceiling	e	$ 199,950,000	if d < 0, then a if c >= a, then a if c < a, then a-d if c >= e, then 0
"Cost Shortfall" amount subject to "Productivity Determinations"	f	$ 24,320,000	if c < e, then e-c
Total productivity % of Adjusted RCS Ceiling	g	12.2%	
Tier 1 "Productivity Discount" %	h	61%	
Total amount of "Cost Shortfall" subject to for "Tier 1 Productivity"	i	$ 9,997,500	if g <= 5%, then f else f * 5%
"Productivity Discount" Tier 1 funds due to HHSC	j	$ 6,098,475	h * i
Tier 2 "Productivity Discount" %	k	82%	
Total amount "Cost Shortfall" subject to for "Tier 2 Productivity"	l	$ 9,997,500	if g <= 10%, then f - i else f * 5%
"Productivity Discount" Tier 2 funds due to HHSC	m	$ 8,197,950	k * l
Tier 3 "Productivity Discount" %	n	TBD%	
Total amount "Cost Shortfall" subject to for "Tier 3 Productivity"	o	$ 4,325,000	
"Productivity Discount" Tier 3 funds due to HHSC	p	TBD	
Total TIER 1, 2, & 3 funds due to HHSC for HHSC "Productivity Discount"**	q	$ 14,296,425	j + m + p
Funds due to HHSC for Unallowable Costs (as determined in cost review)	r	$ 50,000	if d < 0, then 0 if c >= e, then 0 if c < e, then d
Total Net Paid by HHSC	s	**$ 185,653,575**	a - (q+r)

** In Scenario 4 the TIER 3 Productivity Discount would have to be determine before the Total TIER 1, 2, & 3 funds due to HHSC could be determined.

Figure 2: Example RCS and Productivity Share Models

Texas Health and Human Services Commission
Claims Processing & Administration
HHSC Contract # 529-16-0007
Productivity Share Determinations Scenarios and RCS Ceiling Adjustments
Exhibit "C" Figure 2

These scenarios are for purposes of illustration only and will not determine the actual RCS and Productivity Share dollar values.

Scenario 5: **Approved Allowable Costs are Over the original RCS Ceiling**		**Adjustment to RCS Ceiling and Refund All Unallowable Costs**	
RCS Ceiling (Actual Payments)	a	$ 200,000,000	
Annual Report of Allowable Costs	b	$ 206,000,000	
Approved Allowable Costs	c	$ 202,000,000	
Unallowable Costs (as determined by cost review)	d	$ 4,000,000	
Adjusted RCS Ceiling	e	$ 200,000,000	if d < 0, then a if c >= a, then a if c < a, then a-d if c >= e, then 0
"Cost Shortfall" amount subject to "Productivity Determinations"	f	$ -	if c < e, then e-c
Total productivity % of Adjusted RCS Ceiling	g	0.0%	
Tier 1 "Productivity Discount" %	h	61%	
Total amount of "Cost Shortfall" subject to for "Tier 1 Productivity"	i	$ -	if g <= 5%, then f else f * 5%
"Productivity Discount" Tier 1 funds due to HHSC	j	$ -	h * i
Tier 2 "Productivity Discount" %	k	82%	
Total amount "Cost Shortfall" subject to for "Tier 2 Productivity"	l	$ -	if g <= 10%, then f - i else f * 5%
"Productivity Discount" Tier 2 funds due to HHSC	m	$ -	k * l
Tier 3 "Productivity Discount" %	n	TBD%	
Total amount "Cost Shortfall" subject to for "Tier 3 Productivity"	o	$ -	
"Productivity Discount" Tier 3 funds due to HHSC	p	TBD	
Total TIER 1, 2, & 3 funds due to HHSC for HHSC "Productivity Discount"	q	$ -	j + m + p
Funds due to HHSC for Unallowable Costs (as determined in cost review)	r	$ -	if d < 0, then 0 if c >= e, then 0 if c < e, then d
Total Net Paid by HHSC	s	**$ 200,000,000**	a - (q+r)

Figure 2: Example RCS and Productivity Share Models

EXHIBIT C-1

EXHIBIT C
Attachment 1
Financial Cost Standards (FCS)

FCS - 0001
General
CONTRACTOR's Accounting System must maintain accounting records related directly to the performance of the Agreement and maintain accounting records related to the Agreement separate and apart from other corporate accounting records.

FCS - 0002
General
Establish and maintain an Accounting System in accordance with the requirements of the Agreement.

FCS - 0003
General
The CONTRACTOR's methods used in estimating costs must be consistent with the cost accounting practices for accumulating and reporting actual costs, per the Agreement.

FCS - 0004
General
Maintain an Accounting System specifically related to Direct Costs that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial submission and financial statements with all general ledger accounts.

FCS - 0005
General
Deliver the Actual Allowable Cost Report for each of the HHSC Programs.

FCS - 0006
Documentation & Records
Permit authorized governmental representatives of HHSC, HHSC auditors or its agents, Texas State Auditor's Office (SAO) and the federal government full access, both online (on a read-only basis) and in person, during normal business hours, to the accounting records pertaining to the Agreement.

FCS - 0007
General
CONTRACTOR's Fringe Benefit Rate, Common Support Overhead Rate, and Indirect Rate will be consistently applied and remain constant for the personnel who will be performing the

Services on behalf of the contracted entity.

FCS - 0009
General
CONTRACTOR's Fringe Benefit Rate, Common Support Overhead Rate, and Indirect Rate were specifically derived for this Agreement with the State of Texas and will remain appropriately and directly applicable to this Agreement.

FCS - 0010
General
CONTRACTOR will maintain appropriate financial records and follow Generally Accepted Accounting Principles as set forth in the Agreement.

FCS - 0011
General
The Predetermined Rates will remain constant throughout the life of the Agreement and will not be subject to the Retrospective Cost Settlement cost review.

CONTRACTOR acknowledges and agrees that the following percentages will be effective for calculating CONTRACTOR's allowable costs pursuant to the Retrospective Cost Settlement provisions included in the Agreement:

(1) Administrative Service Fee Rate – 16.0036%;

(2) Common Support Overhead Rate – 10.47%;

(3) Indirect Rate – 32.50%; and

(4) Fringe Benefit Rate – 38.37%.

The Predetermined Rates will be applied as depicted in the A-3 Operations Pricing Schedules, and will be utilized for the determination of CONTRACTOR's Allowable Costs for applicable Operational Contract Years pursuant to the Retrospective Cost Settlement provisions included in the Agreement.

FCS - 0012
General
CONTRACTOR's financial reports to HHSC from CONTRACTOR's Accounting System will include salaries and hours, Subcontractors, consultants, travel costs, Pass-Through Expenses, and other non pass-through expenses.

FCS - 0013
Documentation & Records
CONTRACTOR will provide requested accounting records or financial information within fifteen (15) business days of receiving a written request from HHSC or HHSC agents, or within another timeframe as mutually agreed with HHSC or HHSC agents within the 15-day turnaround time limit. CONTRACTOR agrees to reimburse HHSC for all reasonable additional costs and direct damages incurred by HHSC or HHSC agents if such documentation is not made available after an HHSC 5-day pending due date SAR warning notice to CONTRACTOR and if such documentation is not made available within the 15-day turnaround time limit or other timeframe as mutually agreed with HHSC or HHSC agents. Assessment of damages will be based on HHSC's costs in carrying out inspections, audit, review, analysis, and/or functions related to reproduction of documentation at the location(s) of such accounting records.

FCS - 0014
General
Cost classifications, such as Indirect Costs or Direct Costs, will retain that classification in like circumstances and similar purposes throughout the Term. Reclassification in like circumstances and similar purposes is prohibited unless agreed to by the Parties.

FCS - 0016
General
Costs expressly unallowable or mutually agreed to be unallowable, including costs mutually agreed to be unallowable Directly Associated Costs, shall be identified and excluded from any billing, claim, or proposal applicable to this Agreement.

FCS - 0019
General
CONTRACTOR will account for costs appropriately and will maintain records, including supporting documentation, adequate to demonstrate that the actual costs have been incurred and are properly allocable to the Agreement.

FCS - 0023
General
No cost shall be labeled as a Direct Cost if other costs incurred for the same purpose in like circumstances have been labeled as Indirect Costs. Direct Costs of the Agreement shall be charged directly to the Agreement.

FCS - 0024
General
CONTRACTOR's financial reports to HHSC from CONTRACTOR's Accounting System will include, but not be limited to, the following Direct Cost categories:

- Salaries
- Fringe Benefit Rate
- Non-pass-through expenses
- Subcontractors
- Consultants
- Pass-Through Expenses

CONTRACTOR's financial reports to HHSC from CONTRACTOR's Accounting System will include, but not be limited to, the following Indirect Cost categories:

- Common Support Overhead Rate
- Indirect Rate.

FCS - 0025
General
The Accounting System will maintain accounting records related directly to the performance of the Agreement, and will separate expenditures for medical benefit costs from administrative costs. Further, the records will be maintained separate and apart from other corporate accounting records.

FCS - 0026
General
Retain adequate documentation necessary to support and verify all costs submitted to HHSC for reimbursement, including proper invoices, underlying accounting records, and/or other documents to support all payables and intercompany charges.

FCS - 0027
General
Maintain separate administrative accounting transactions from accounting transactions related to cost containment Functional Requirements.

FCS - 0028
General
Maintain separate programmatic records, including but not limited to, expenditures for medical benefit costs for each cost containment Functional Requirement.

FCS - 0029
General
Submit a final accounting policy manual within 180 days of Effective Date of the Agreement. Any modifications applied to the final accounting policy manual must be agreed by the Parties prior to implementation of any change.

FCS - 0030
Documentation & Records
Cooperate with HHSC, HHSC auditors, Texas State Auditor's Office (SAO) and the federal government in their inspections, audits, and/or review of any accounting/financial records, and provide their governmental representatives with all necessary records and information. It is the responsibility of a CONTRACTOR to provide adequate documentation and justification to the authorized governmental representatives of the state and the federal government during the inspection, audit and/or review process for all costs included in the accounting records of the CONTRACTOR, including those that reflect financial transactions between CONTRACTOR and all Subcontractors, suppliers, or other parties the CONTRACTOR hires, retains, or otherwise employs or pays for goods or services related to the performance of this Agreement."

FCS - 0033
General
Provide HHSC a monthly report of the CONTRACTOR's Allowable Costs in a format, content and media approved by the State, as soon as possible but no later than the 25th day of the month following the month in which they are incurred, unless otherwise agreed by the Parties. In addition, the report will also identify total costs by business functional area. Unless previously disclosed, each cost summary will fully disclose the financial impact of all transactions with any Subsidiary either under a formal or informal arrangement that would relate to the performance under the Agreement. The methodologies and assumptions supporting cost allocations must be disclosed.

FCS - 0036
General
Provide financial statements no later than 90 days after the end of each Operational Contract Year or after the termination of this Agreement. The financial statements will depict the Fees

paid to CONTRACTOR compared to the Allowable Costs incurred by the CONTRACTOR as a result of Services performed for the preceding Operational Contract Year, including the applicable Administrative Service Fee Rate. The financial statements will follow the principles included in the Exhibit C, Attachment 2: Cost Principle Manual.

EXHIBIT C
Attachment 1
Financial Cost Standards (FCS)

FCS - 0001
General
CONTRACTOR's Accounting System must maintain accounting records related directly to the performance of the Agreement and maintain accounting records related to the Agreement separate and apart from other corporate accounting records.

FCS - 0002
General
Establish and maintain an Accounting System in accordance with the requirements of the Agreement.

FCS - 0003
General
The CONTRACTOR's methods used in estimating costs must be consistent with the cost accounting practices for accumulating and reporting actual costs, per the Agreement.

FCS - 0004
General
Maintain an Accounting System specifically related to Direct Costs that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial submission and financial statements with all general ledger accounts.

FCS - 0005
General
Deliver the Actual Allowable Cost Report for each of the HHSC Programs.

FCS - 0006
Documentation & Records
Permit authorized governmental representatives of HHSC, HHSC auditors or its agents, Texas State Auditor's Office (SAO) and the federal government full access, both online (on a read-only basis) and in person, during normal business hours, to the accounting records pertaining to the Agreement.

FCS - 0007
General
CONTRACTOR's Fringe Benefit Rate, Common Support Overhead Rate, and Indirect Rate will be consistently applied and remain constant for the personnel who will be performing the

Services on behalf of the contracted entity.

FCS - 0009
General
CONTRACTOR's Fringe Benefit Rate, Common Support Overhead Rate, and Indirect Rate were specifically derived for this Agreement with the State of Texas and will remain appropriately and directly applicable to this Agreement.

FCS - 0010
General
CONTRACTOR will maintain appropriate financial records and follow Generally Accepted Accounting Principles as set forth in the Agreement.

FCS - 0011
General
The Predetermined Rates will remain constant throughout the life of the Agreement and will not be subject to the Retrospective Cost Settlement cost review.

CONTRACTOR acknowledges and agrees that the following percentages will be effective for calculating CONTRACTOR's allowable costs pursuant to the Retrospective Cost Settlement provisions included in the Agreement:

(1) Administrative Service Fee Rate – 16.0036%;

(2) Common Support Overhead Rate – 10.47%;

(3) Indirect Rate – 32.50%; and

(4) Fringe Benefit Rate – 38.37%.

The Predetermined Rates will be applied as depicted in the A-3 Operations Pricing Schedules, and will be utilized for the determination of CONTRACTOR's Allowable Costs for applicable Operational Contract Years pursuant to the Retrospective Cost Settlement provisions included in the Agreement.

FCS - 0012
General
CONTRACTOR's financial reports to HHSC from CONTRACTOR's Accounting System will include salaries and hours, Subcontractors, consultants, travel costs, Pass-Through Expenses, and other non pass-through expenses.

FCS - 0013
Documentation & Records
CONTRACTOR will provide requested accounting records or financial information within fifteen (15) business days of receiving a written request from HHSC or HHSC agents, or within another timeframe as mutually agreed with HHSC or HHSC agents within the 15-day turnaround time limit. CONTRACTOR agrees to reimburse HHSC for all reasonable additional costs and direct damages incurred by HHSC or HHSC agents if such documentation is not made available after an HHSC 5-day pending due date SAR warning notice to CONTRACTOR and if such documentation is not made available within the 15-day turnaround time limit or other timeframe as mutually agreed with HHSC or HHSC agents. Assessment of damages will be based on HHSC's costs in carrying out inspections, audit, review, analysis, and/or functions related to reproduction of documentation at the location(s) of such accounting records.

FCS - 0014
General
Cost classifications, such as Indirect Costs or Direct Costs, will retain that classification in like circumstances and similar purposes throughout the Term. Reclassification in like circumstances and similar purposes is prohibited unless agreed to by the Parties.

FCS - 0016
General
Costs expressly unallowable or mutually agreed to be unallowable, including costs mutually agreed to be unallowable Directly Associated Costs, shall be identified and excluded from any billing, claim, or proposal applicable to this Agreement.

FCS - 0019
General
CONTRACTOR will account for costs appropriately and will maintain records, including supporting documentation, adequate to demonstrate that the actual costs have been incurred and are properly allocable to the Agreement.

FCS - 0023
General
No cost shall be labeled as a Direct Cost if other costs incurred for the same purpose in like circumstances have been labeled as Indirect Costs. Direct Costs of the Agreement shall be charged directly to the Agreement.

FCS - 0024
General
CONTRACTOR's financial reports to HHSC from CONTRACTOR's Accounting System will include, but not be limited to, the following Direct Cost categories:

- Salaries
- Fringe Benefit Rate
- Non-pass-through expenses
- Subcontractors
- Consultants
- Pass-Through Expenses

CONTRACTOR's financial reports to HHSC from CONTRACTOR's Accounting System will include, but not be limited to, the following Indirect Cost categories:

- Common Support Overhead Rate
- Indirect Rate.

FCS - 0025
General
The Accounting System will maintain accounting records related directly to the performance of the Agreement, and will separate expenditures for medical benefit costs from administrative costs. Further, the records will be maintained separate and apart from other corporate accounting records.

FCS - 0026
General
Retain adequate documentation necessary to support and verify all costs submitted to HHSC for reimbursement, including proper invoices, underlying accounting records, and/or other documents to support all payables and intercompany charges.

FCS - 0027
General
Maintain separate administrative accounting transactions from accounting transactions related to cost containment Functional Requirements.

FCS - 0028
General
Maintain separate programmatic records, including but not limited to, expenditures for medical benefit costs for each cost containment Functional Requirement.

FCS - 0029
General
Submit a final accounting policy manual within 180 days of Effective Date of the Agreement. Any modifications applied to the final accounting policy manual must be agreed by the Parties prior to implementation of any change.

FCS - 0030
Documentation & Records
Cooperate with HHSC, HHSC auditors, Texas State Auditor's Office (SAO) and the federal government in their inspections, audits, and/or review of any accounting/financial records, and provide their governmental representatives with all necessary records and information. It is the responsibility of a CONTRACTOR to provide adequate documentation and justification to the authorized governmental representatives of the state and the federal government during the inspection, audit and/or review process for all costs included in the accounting records of the CONTRACTOR, including those that reflect financial transactions between CONTRACTOR and all Subcontractors, suppliers, or other parties the CONTRACTOR hires, retains, or otherwise employs or pays for goods or services related to the performance of this Agreement."

FCS - 0033
General
Provide HHSC a monthly report of the CONTRACTOR's Allowable Costs in a format, content and media approved by the State, as soon as possible but no later than the 25th day of the month following the month in which they are incurred, unless otherwise agreed by the Parties. In addition, the report will also identify total costs by business functional area. Unless previously disclosed, each cost summary will fully disclose the financial impact of all transactions with any Subsidiary either under a formal or informal arrangement that would relate to the performance under the Agreement. The methodologies and assumptions supporting cost allocations must be disclosed.

FCS - 0036
General
Provide financial statements no later than 90 days after the end of each Operational Contract Year or after the termination of this Agreement. The financial statements will depict the Fees

paid to CONTRACTOR compared to the Allowable Costs incurred by the CONTRACTOR as a result of Services performed for the preceding Operational Contract Year, including the applicable Administrative Service Fee Rate. The financial statements will follow the principles included in the Exhibit C, Attachment 2: Cost Principle Manual.

EXHIBIT C-2

I. General

A. Introduction

This Cost Principles Manual ("CPM"), contains principles establishing the allowability or unallowability of administrative expenses, subcontract expenses, and other expenses relative to the Agreement. The allowability or unallowability of expenses impact the actual Allowable cost reports per requirements FCS - 0033 and FCS - 0036. A cost is allowable if it is incurred specifically for the performance of the Services and Deliverables under this Agreement, and if the cost conforms to the policies, principles, and requirements of the Agreement.

All costs reported are subject to the cost allowability requirements under the Agreement. All Direct Costs, Subsidiary transactions, consultants and Subcontracts are subject to the allowability tests and requirements as set forth in the Agreement, except where HHSC specifically allows an exception as documented in this Agreement. In case of any conflicts between the Agreement and Generally Accepted Accounting Principles (GAAP), the Agreement prevails.

Pursuant to FCS - 0011, the Predetermined Rates are allowable and allocable under the Agreement, and will remain constant throughout the Term of the Agreement and the rates, and their component costs, will not be subject to Retrospective Cost Settlement reviews.

B. Federal disallowance/recoupment

If the federal government recoups money from the state for expenses or costs the federal government deems unallowable, the state then has the right to recoup payments made to the CONTRACTOR for these same expenses or costs. If the state did not previously disallow such expenses, the state shall: 1) make good faith efforts to challenge the federal government's recoupment of funding for such expenses, subject to its obligations under applicable law, 2) promptly notify CONTRACTOR of any such state disallowance of an expense due to federal recoupment, and 3) cooperate with CONTRACTOR to execute an Amendment pursuant to Article 9 of the Agreement for the purpose of adjusting CONTRACTOR'S Services and Fees to avoid any ongoing obligation by CONTRACTOR to incur the costs disallowed by the state. Going forward, the state would deem any similar expenses or costs unallowable. If the state retroactively recoups money from the CONTRACTOR due to a federal disallowance, the state will recoup the entire amount paid to the CONTRACTOR for the federally disallowed expenses or costs, not just the federal portion. These costs will be unallowable under the terms of the Agreement.

C. Subsidiary Transactions and Cost Reporting

Inter-company profits and margins related to all transactions with any Subsidiary organization, including inter-company profits and margins related to all transactions of the CONTRACTOR or the CONTRACTOR's Subsidiary are unallowable under the terms of the Agreement.

II. Definitions

Actual Allowable Cost Report means the actual allowable cost reports per requirements FCS - 0033 and FCS - 0036.

Allocable Cost means a cost that is allocable to the Agreement if the direct goods or direct services involved are specifically chargeable or assignable to the Agreement in accordance with relative benefits received. Any cost allocable to the Agreement under the principles provided for in this document may not be charged to other Texas contracts, nor shall other contracts' costs be charged to this Agreement, either to overcome deficiencies or for other reasons. The term "other contracts" does not include subcontracts to the Agreement. No costs in violation of the Agreement will be allocable.

Allowable Cost are defined as costs that may be reported on the Actual Allowable Cost report. To be allowable, costs must:

1. Conform to the requirements of this Agreement which include being Reasonable and Allocable;
2. Be related to the Performance of this Agreement;
3. Be incurred during the specific Operational Contract Year for which they are charged;
4. Not be recovered or reimbursable from another source;
5. Be net of all applicable credits;
6. Be adequately documented;
7. Be authorized or not prohibited under state laws, state regulations or any provision included in this Agreement;
8. Be in conformity with any limitations or exclusions set forth in the Agreement, laws, or other regulations specifically governing HHSC Programs;
9. Except as otherwise provided for in the Agreement, be determined in accordance with Generally Accepted Accounting Principles;
10. Not be included as a reimbursable cost or used to meet cost sharing requirements of any other activity of the CONTRACTOR under a different agreement during the Term of the Agreement; and
11. Be consistent with the CONTRACTOR's normal treatment of the expense, regardless of how Subsidiaries may treat similar expenses. A cost may not be assigned to this Agreement as a Direct Cost if any other cost incurred by CONTRACTOR for the same purpose in like circumstances has been allocated to a different contract with the state as an Indirect Cost.

Direct Costs means those costs that can be identified specifically with and are readily assignable to the objectives of the Agreement. A particular type of cost may benefit one or more other activities of the CONTRACTOR, but a portion of such cost may be readily assignable to the Agreement and accordingly be treated as a Direct Cost. For example, a particular Employee may perform services that benefit more than one activity; however, if the time spent on each of the activities can be identified and distributed to those activities through a personnel activity report, the amount of the Employee's compensation distributed to each activity is a Direct Cost for that activity. Costs that can be specifically identified with and assigned to the activities under the Agreement are generally categorized as Direct Costs.

Directly Associated Cost is any cost that is generated solely as a result of incurring another cost, and that would not have been incurred had the other cost not been incurred. When an unallowable cost is incurred, its directly associated costs are also unallowable.

Fringe Benefits are allowances and services provided by employers to their employees as compensation

in addition to regular salaries and wages. The following standards apply:

1. CONTRACTOR's fringe benefits include employer contributions or expenses for social security; payroll taxes; employee leave; employee life, health, unemployment, and worker's compensation insurance; pensions; bonuses; and other similar benefits. Except as provided elsewhere in these principles, the costs of fringe benefits are allowable if the benefits are Reasonable and are required by law, the CONTRACTOR employee agreement, or an established policy of the CONTRACTOR.
2. The cost of fringe benefits in the form of regular compensation paid to employees during periods of authorized absences from the job, such as for annual leave, sick leave, holidays, court leave, military leave, and other similar benefits, are allowable if: (a) they are provided under established written leave policies; (b) the costs are equitably allocated to all of the related activities of the CONTRACTOR; and (c) the accrual basis of accounting utilized for costing each type of leave is consistently followed by the CONTRACTOR.
3. The accrual basis may be used only for those types of leave for which a liability as defined by Generally Accepted Accounting Principles ("GAAP") exists when the leave is earned. When the CONTRACTOR uses the accrual basis of accounting in accordance with GAAP and complies with the other provisions of this Article, leave costs are allowable.
4. The cost of fringe benefits in the form of employer contributions or expenses for social security; payroll taxes; employee life, health, unemployment, and worker's compensation insurance; pension plan costs; bonuses; and other similar benefits are allowable, provided these benefits are granted under established written policies. These benefits, whether treated as Indirect Costs or as Direct Costs, must be allocated to the Agreement and all other activities of the CONTRACTOR in a manner consistent with the pattern of benefits attributable to the individuals or group(s) of employees whose salaries and wages are chargeable to the Agreement.
5. Fringe benefits costs are allowable in the Fringe Benefit rate as depicted in FCS - 0011.

Fringe Benefit Rate is the rate set forth in the Agreement and FCS - 0011.

Indirect Costs means those costs components that constitute the Indirect Rates. Without limiting Section I(A) of this CPM, these costs are incurred for a common or joint purpose benefiting the Agreement and one or more other activities of the CONTRACTOR and are not readily assignable to the activities specifically benefited, without effort disproportionate to the results achieved. To facilitate equitable distribution of Indirect Costs to the activities benefited, it may be necessary to establish a number of pools of Indirect Costs within the various departments of the CONTRACTOR. Indirect Cost pools should be distributed to activities benefited on bases that will produce an equitable result in consideration of relative benefits derived. For the purposes of distributing Indirect Cost pools to the Agreement, the CONTRACTOR is not allowed to include any Indirect Costs which do not benefit the objectives under the Agreement. For the purposes of this Agreement the Indirect Costs will be the following:

1. Common Support Overhead costs – these costs will include costs related to Employee payroll distribution, Employee security, data protection, and Employee technology services, such as enablement portals.
2. Indirect Costs (including Functional Overhead, Portfolio Overhead, and G&A) - These costs include corporate costs, such as training not required by the contract scope of services, career development, and compliance, that enable Employees to perform certain types of work, both from a functional

perspective, such as a specific technology, and from an industry perspective, such as a specific state government service like Medicaid. These costs also include corporate administration functions that support corporate-level activities related to subcontracting and purchasing, like buyers, procurement systems, price negotiators, and corporate administrators. These costs also include corporate general and administrative costs to pay for individuals that support corporate controllership, tax, treasury, the c-suite, office staff, etc.

Provider Relations activities include face-to-face educational visits, educational phone calls, on-site training, webinars, recruiting of state health care program providers, speaking at provider association meetings and conferences, participating in THSteps experts forums, and disseminating program awareness materials. The costs of printing and distributing provider directories, provider manuals, and member handbooks are Pass-Through Expenses. The classification as Provider Relations prevails over a potential unallowable classification.

Reasonable as applied to any cost incurred by CONTRACTOR means a cost that, when considered in the totality of the circumstances in which it was incurred, is not fraudulent, manifestly inordinate, plainly unjustifiable, a violation of the public trust or incurred in bad faith. Determinations of whether a cost is Reasonable shall be based solely and exclusively on the foregoing standard, and without reference to customary usage, statutory definitions or common law interpretations of the word "reasonable". In no event shall the mere identification of comparable and available goods or services that would solely result in a lesser cost than a cost incurred by CONTRACTOR result in a determination that such CONTRACTOR cost is not Reasonable.

Costs incurred by CONTRACTOR shall be presumed to be Reasonable, and shall only be determined to not be Reasonable by clear and convincing evidence.

The assessment of Reasonableness, as defined herein, shall only apply to the RCS process set forth in Exhibit C. For the RCS, Reasonableness shall apply to the Direct Costs included on the Allowable Cost Report. The concept of Reasonableness as defined herein shall not apply outside of this context.

Factors to be considered in the determination of Reasonableness shall include, but not be limited to the following (in no order of priority):

1. The cost incurred is one that by its nature has previously been incurred by CONTRACTOR in the conduct of the TMMIS operations.
2. The cost incurred is not unwarranted in the historical context of CONTRACTOR's operations of the TMMIS given the circumstances presented to CONTRACTOR at the incurrence, even if not previously incurred by CONTRACTOR.
3. The cost incurred was disclosed in Exhibit D of predecessor contract #529-14-0125-0003 between the Parties, or for purposes of an Amendment or a Change Order, the cost was disclosed in the original pricing for such Amendment or Change Order.
4. Market prices for comparable (*e.g.,* quality, amount, duration, availability, etc.) goods or services for the geographic area at the time of incurrence.
5. The cost incurred is temporally consistent with, and/or necessary to achieve, the Mission and Objectives of the Agreement.
6. CONTRACTOR's established organizational practices.

7. Third Party transactions with Subcontractors or suppliers are the result of negotiations and consistent with the ethical principles of the Agreement.
8. The cost incurred does not act to unjustifiably increase the Allowable Costs of the Agreement.

Subsidiary for purposes of this CPM means an entity which CONTRACTOR controls, whether in whole or part, and also means a relationship in which CONTRACTOR is controlled, whether in whole or part, by another entity. Subsidiary and affiliate are synonymous terms for purposes of this CPM. Any Subsidiary costs incurred by CONTRACTOR for the Agreement will be recorded into CONTRACTOR's accounting records for the Agreement without Subsidiary profit. Subsidiary costs will be recorded in the Direct Cost category as defined in FCS - 0024.

III. Applicable Credits

Applicable credits refer to those receipts or reduction of expenditure-type transactions that offset or reduce cost items allocable to the Agreement as Direct or Indirect Costs. Examples of these transactions are: purchase discounts; rebates or allowances; recoveries or indemnities on losses; insurance refunds or rebates; and adjustments of overpayments or erroneous charges. To the extent that these credits accruing to or received by the CONTRACTOR relate to Allowable Costs, they must be credited to this Agreement as a cost reduction in the Actual Allowable Cost Report. This Section III does not apply to Contingency Fees.

IV. Application of Indirect Rates

CONTRACTOR will apply indirect rates to the Actual Allowable Cost report as follows:

1. Common Support Overhead Rate: A rate of 10.47% will be applied to the total salaries and fringe benefits of all CONTRACTOR Employees. This 10.47% Common Support Overhead Rate represents all costs included in the Common Support and Overhead definition included in Section II of this document and that may be applied by the CONTRACTOR. This rate does not include any profit.
2. Indirect Rate: A rate of 32.50% will be applied to all salaries, fringe benefits, Subcontractors, consultants, travel, and other non-pass through expenses. This 32.50% Indirect Rate represents all costs included in the Indirect Costs definition included in Section II of this document and that may be applied by CONTRACTOR. This rate does not include any profit.

CONTRACTOR agrees that these rates, as applicable, will be effective for any and all Amendments executed during the Term of the Agreement. CONTRACTOR further acknowledges and agrees that these rates will be calculated as depicted above for the Term of the Agreement.

V. Cost Categories

1. Accounting. The cost of establishing and maintaining accounting and other information systems is allowable.
2. Add-on Fees. Amounts paid to a Subsidiary that are in excess of actual costs incurred by the Subsidiary, or that do not represent a pass-through of the actual costs of the Subsidiary, are unallowable for cost-reporting on the Actual Allowable Cost Report. This includes profit, margin, or mark-ups added to, or included in, Subsidiary costs.
3. Administrative Assessments. Any administrative services fees paid to, or assessed by, a Subsidiary are unallowable for cost-reporting on the Actual Allowable Cost Report.
4. Advertising Costs. Cost incurred for advertising of the CONTRACTOR or any Subcontractor products or services is unallowable, except when required specifically by Exhibit B or if used specifically for help-wanted advertising of FTEs with the requirement that such help wanted advertising is for a position or class of positions directly related to this Agreement.
5. Advisory Councils. Costs incurred by advisory councils or committees are unallowable.
6. Alcoholic Beverages. Costs of alcoholic beverages are unallowable.

7. Audit Services. The costs of audits are unallowable, except for the following items in support of the scope of services:
   a. Desk Review Audits, reviewing provider cost reports to ensure the providers are paid the correct amounts as well as the calculation of their rates
   b. Field audits, performing annual audits on children's hospitals
   c. External Audit Liaison, acting as the external audit liaison between external groups auditing TMHP
   d. FQHC and RHC Rate Determination, determining the rates for FQHC and RHC providers
   e. Monthly Cost Settlement Information, providing a monthly report to HHSC detailing information about all cost settlements fiscal year to date
8. Automatic Electronic Data Processing. The cost of data processing services directly related to the performance of this Agreement is allowable.
9. Bad Debts. Any losses arising from uncollectible accounts and other claims, and associated costs such as collections costs and legal costs, are unallowable.
10. Bonding Costs. Costs of bonding Employees and officials are unallowable.
11. Bond issuance cost amortization. Amortization of the costs involved in issuing bonds is unallowable. Similarly, bond discounts and other costs of financing are also unallowable.
12. Capital expenditures. Expenditures for capital equipment as defined in the Agreement are allowable as Pass-Through Expenses. Improvements or repairs that materially increase the value or useful life of buildings or equipment are unallowable except as expressly agreed to by HHSC.
13. Communications. Costs of telephone, mail, courier service, and similar communication services are allowable.
14. Compensation for Accenture Federal Services employees. Costs for work performed by employees of CONTRACTOR'S United States federal government business affiliate, Accenture Federal Services, LLC, are unallowable.
15. Compensation for Personnel Services.
   a. General. Compensation for personnel services includes all remuneration, paid currently or accrued, for services rendered during the period of performance under the Agreement, including wages, salaries, and fringe benefits. The costs of compensation are allowable if they satisfy the specific requirements of the Agreement, and the total compensation for individual Employees:
      i. Is Reasonable for the services rendered and conforms to the established policy of CONTRACTOR consistently applied to all of its activities; and
      ii. Is determined and supported as provided in this CPM.
   b. Unallowable Costs. Costs that are unallowable under other sections of the Agreement will not be allowable under this CPM solely on the basis that they constitute personnel compensation
   c. Fringe benefits costs are allowable in the Fringe Benefit Rate as depicted in FCS - 0011.
   d. Employee bonuses or incentive payments outside of the base calculation of the Fringe Benefit Rate are unallowable.
16. Contingencies. Contributions to a contingency reserve or any similar provision, which is created to

cover the costs of events or occurrences that cannot be foretold with certainty as to time, or intensity, or with an assurance of their happening, are unallowable.

17. Contributions and Donations. Contributions and donations, including cash, property, and services, regardless of the recipient, are unallowable.
18. Cost of capital. Costs representing the cost of capital in any manner are unallowable. For avoidance of doubt, this provision does not waive CONTRACTOR's rights under the Prompt Payment Act.
19. Defense and Prosecution costs and attorney's fees of criminal, civil, and administrative proceedings for CONTRACTOR's purposes are unallowable.
20. Depreciation and Amortization. Depreciation and amortization are unallowable under the terms of this Agreement.
21. Dispute Resolution and Arbitration. Dispute resolution and arbitration costs are unallowable. For avoidance of doubt, this provision does not waive CONTRACTOR's rights to seek actual damages as permitted by law or under the Agreement.
22. Economic Planning. Costs for general long-range management planning that is concerned with the future overall development of the CONTRACTOR's business and that may take into account the eventual possibility of economic dislocations or fundamental alterations in those markets in which the CONTRACTOR currently does business are unallowable.
23. Employee Morale. All costs for Employee morale are unallowable, except costs for voluntary Employee participation in company-sponsored events designed to improve Employee engagement, team work, and retention up to one (1) hour per quarter per Employee, as actually incurred.
24. Entertainment. Costs of entertainment, including amusement, diversion, and social activities and any costs directly associated with such costs (such as tickets to shows or sports events, meals, lodging, rentals, transportation, and gratuities) are unallowable.
25. Fines and Penalties. Fines, penalties, damages, and other settlements resulting from violations (or alleged violations) of, or failure of the unit to comply with, federal, state, or local laws and regulations assessed against CONTRACTOR or Subcontractors, are unallowable.
26. Gains and Losses from Asset Impairment. Cost related to gains or losses from the sale, retirement, or other disposition of depreciable property is unallowable.
27. Goodwill. Any costs for amortization, expensing, write-off, or write-down of goodwill (however represented) are unallowable.
28. Income taxes. Federal, state, and local taxes on CONTRACTOR income are unallowable. This includes excess profit taxes; corporate income taxes paid by a Subsidiary; and other income taxes paid by a Subsidiary.
29. Investment Management Costs. Costs of investment counsel and staff and similar costs incurred to enhance income from investments are unallowable.
30. Liquidated Damages. Liquidated Damages are unallowable.
31. Idle Facilities and Idle Capacity.
    a. As used in this Section the following terms have the meanings set forth below:
        i. Facilities means land and buildings or any portion thereof, equipment individually or collectively, or any other tangible capital asset, wherever located, and whether owned or

leased by the CONTRACTOR.

ii. Idle facilities means completely unused facilities that are excess to the CONTRACTOR's current needs.

iii. Idle capacity means the unused capacity of partially used facilities. It is the difference between (a) that which a facility could achieve under 100 percent operating time on a one-shift basis less operating interruptions resulting from time lost for repairs, setups, unsatisfactory materials, and other normal delays, and (b) the extent to which the facility was actually used to meet demands during the accounting period. A multi-shift basis should be used if it can be shown that this amount of usage would normally be expected for the type of facility involved.

iv. Cost of idle facilities or idle capacity means costs such as maintenance, repair, housing, rent, and other related costs, e.g., insurance, interest, and depreciation or use allowances.

b. The costs of idle facilities and idle capacity are unallowable, unless:

i. specifically approved by HHSC, or resulting from changes in requirements of the Agreement that result in idle facilities or idle capacity;

ii. such costs, as anticipated in the A-3 Operations Pricing Schedules, are Pass-Through Expenses; or

iii. they result from other causes which were not as a result of CONTRACTOR negligence or breach of the Agreement.

Nothing in the foregoing limits CONTRACTOR's duty to minimize idle facilities and idle capacity.

32. Insurance. Costs related to insurance are unallowable except as specifically allowed in the Agreement.

33. Interest. Interest expense is unallowable. This includes interest expense incurred by a Subsidiary. Costs incurred for interest on borrowed capital or the use of the CONTRACTOR 's own funds, however represented, are unallowable.

34. Lobbying. The cost of activities associated directly or indirectly with influencing local state or federal legislation is unallowable.

35. Maintenance, Operations, and Repairs. Unless prohibited by law, the cost of utilities, insurance, security, janitorial services, elevator service, upkeep of grounds, necessary maintenance, normal repairs and alterations, and the like are allowable either as incurred as part of a rental agreement or as incurred as part of a separate vendor service agreement, but costs for duplicative services for the same period are unallowable.

36. Marketing Costs. Cost incurred for marketing of CONTRACTOR or any Subcontractor products or services is unallowable.

37. Materials and Supplies. The cost of materials and supplies is allowable. Purchases should be charged at their actual prices after deducting all Allocable cash discounts, trade discounts, rebates, and allowances received on a pro rata basis.

38. Memberships, Subscriptions, and Professional Activities.

a. Costs of the CONTRACTOR's memberships in business, technical, and professional

organizations are allowable.

b. Costs of the CONTRACTOR's subscriptions to business, professional, and technical periodicals are allowable.

c. Costs of meetings and conferences where the primary purpose is the dissemination of technical information, including meals, transportation, rental of meeting facilities, and other incidental costs are allowable, subject to the limitations of this CPM.

d. Costs of membership in civic and community social organizations are unallowable.

e. Costs of membership in organizations substantially engaged in lobbying are unallowable.

39. Organization Costs. Cost for CONTRACTOR or any Subcontractor to reorganize their corporate or proprietary organizations for any reason are unallowable.

40. Other Contract Losses. An excess of costs over income under any other contract is unallowable.

41. Pre-implementation Costs. Pre-implementation costs are certain costs incurred prior to the Effective Date of the Agreement. Pre-implementation costs are unallowable. Costs incurred prior to the notification of the award, either in anticipation of this award, or in connection with contract negotiations, bid preparation, or RFP submission, etc., are unallowable. This does not include HHSC approved Transition Costs or the Amendments set forth in Exhibit D.

42. Professional Service Costs. Costs of professional and consultant services rendered by persons or organizations that are members of a particular profession or possess a special skill, whether or not officers, are professional services costs. Cost of professional and consultant services rendered by persons or organizations who are not officers or Employees of the CONTRACTOR are allowable.

43. Proposal Costs. Costs of preparing proposals are unallowable, except for the cost of preparing Change Orders or Amendments to address HHSC priorities pursuant to Article 9 of the Agreement.

44. Provider Relation Costs. The costs are allowable.

45. Public Relations Costs. These costs are unallowable (including ownership or shareholder meetings), except when specifically required by the Agreement; or if responding to inquiries on company policies and activities specifically related to the Agreement; or if communicating with the public, press specifically related to the Agreement; or conducting general liaison with news media and Government public relations officers on Agreement-related matters; or participating in community service activities.

46. Publication and Printing Costs. Publication costs, including the costs of printing (including the processes of composition, plate-making, presswork, binding, and the end products produced by such processes), distribution, promotion, mailing, and general handling are allowable.

47. Rebates and Profit Sharing. Unless specifically allowed by the Agreement any profit sharing or rebate arrangement between the CONTRACTOR and a Subcontractor is unallowable. Likewise, any fees or assessments between an operating subsidiary and an affiliate company, which are not tied to specifically identified services that directly benefit the Agreement, such that the fee is effectively a form of profit payment or rebate to the affiliate, are unallowable unless specifically allowed by the Agreement.

48. Relocation Costs. Unless specifically approved by HHSC, relocation costs, which are costs resulting from the permanent change of assigned work location of an existing Employee or new Employee, are unallowable. A request by HHSC to remove personnel pursuant to Section 8.10 of the Agreement

will not be construed as approval of associated Relocation Costs.

49. Rental Costs. Rental costs are allowable provided:
    a. rates are Reasonable compared to the market;
    b. costs are limited in a sale and leaseback arrangement to the same costs that would have been incurred if the title had been retained;
    c. renting is not between Subsidiaries or divisions of the same organization; and
    d. that costs do not exceed the normal cost of ownership.
50. Royalties. Costs related to royalties on a patent or amortization of the cost of purchasing a patent or patent rights necessary for the performance of the Agreement and applicable to Agreement products or processes are allowable unless the State has a license or the right to a free use of the patent, the patent has been deemed to be invalid, the patent is considered to be unenforceable or the patent is expired.
51. Selling Costs. Selling costs are unallowable.
52. Service and Maintenance Costs. Costs arising from fulfillment of any contractual obligation of CONTRACTOR or any of its Subcontractor to provide services such as installation, maintenance, enhancements, and training are allowable.
53. Warranty Costs. Cost incurred by CONTRACTOR in accordance with Section 12.03 of the Agreement above and beyond the costs for resources performing Service and Maintenance Costs, as described in Item #52, are unallowable.
54. Taxes. Local and State taxes paid by CONTRACTOR or Subcontractors to local or state governments outside of Texas (other than hotel, airline and sales taxes expended specifically for the Agreement) are unallowable. In addition, CONTRACTOR's Federal taxes (other than hotel, airline and sales taxes expended specifically for the Agreement) are unallowable.
55. Training. The cost of training for CONTRACTOR Employees and Subcontractors to fulfill the requirements of the Agreement are allowable.
56. Travel costs.
    a. General. Travel costs are allowable only as a Direct Cost for expenses for transportation, lodging, subsistence, and related items incurred by Employees traveling on official business specifically related to the Agreement. Such costs may be charged on an actual cost basis, on a per diem or mileage basis in lieu of actual costs incurred, or on a combination of the two, provided the method used is applied to an entire trip, and results in charges consistent with those normally allowed in like circumstances in all other activities of the CONTRACTOR.
    b. Lodging and subsistence. Costs incurred by Employees and officers for travel, including costs of lodging, other subsistence, and incidental expenses, will be allowable to the extent the costs do not exceed charges normally allowed by the CONTRACTOR in its regular operations as a result of the CONTRACTOR's policy as described in Attachment 3 to Exhibit C. In the absence of a written policy regarding travel costs, the rates and amounts of travel will be allowed only as part of a plan reviewed in advance by HHSC and subject to audit.
    c. Commercial air travel. Airfare costs in excess of the customary standard (coach or equivalent) airfare are unallowable unless approved by CONTRACTOR leadership with appropriate documentation of an exception.

d. Air travel by other than commercial carrier. Cost of travel by the CONTRACTOR-owned, - leased, or -chartered aircraft, as used in this CPM, includes the cost of lease, charter, operation (including personnel costs), maintenance, depreciation, interest, insurance, and other related costs. Costs of travel via the CONTRACTOR-owned, - leased, or -chartered aircraft are unallowable to the extent they exceed the cost of allowable commercial air travel.

VI. Other Costs

Any other costs incurred by the CONTRACTOR or any of its Subcontractors, which are not included in this CPM, for the completion of any contractual requirement will not be allowed unless they are approved in advance by HHSC and meet the criteria for Allowable Costs as defined in this CPM. Any legal commitments by CONTRACTOR to make any payments to other parties (or any actual payments made to other parties) will not overrule the requirements of this CPM.

EXHIBIT C-3

This Accounting Policy Manual (APM) contains the mechanics, and rules for how CONTRACTOR records, reports, and reviews the financial transactions and outcomes of the Agreement, based on the principles and requirements contained in Exhibit C-2, the HHSC TMMIS Cost Principle Manual (CPM), and in Exhibit C-1, the Financial Control Standards (FCS) of this Agreement.

This APM and its contents are effective on the Operational Start Date, unless otherwise noted in the APM. Should changes be necessary to the manual, those changes must be a collaborative effort between the Parties. The revised manual must be approved by HHSC as required by Article 9 of the Agreement. Revisions would be recorded in a revisions section to be added at the end of the manual, when necessary. That section would record the information being replaced, as well as the new information, and the effective date for the new information.

The key sections included in this manual are:

I. Accounting System
II. Accounting for Direct Costs
III. Accounting for Indirect Costs
IV. Accounting for Administrative Service Fee
V. Financial Reporting Timing and Approach
VI. Retrospective Cost Review and Productivity Share Determination
VII. Travel Policy
VIII. Billing Approach
IX. Audits

I. Accounting System.

CONTRACTOR maintains an "Accounting System", consisting of a collective set of processes, procedures, and methodologies, sourced from various inputs, including but not limited to various computerized systems, actual vendor invoices and contracts, manuals and requirements, and spreadsheet tools. CONTRACTOR maintains this system in accordance with FCS - 0001, FCS - 0002, FCS - 0004, FCS - 0012, FCS - 0024, and FCS - 0025.

CONTRACTOR uses spreadsheet tools, as part of the Accounting System, to provide the following:

1. Transaction registers and totals for types of costs in a manner that substantially imitates how reconciliations with a general ledger are typically performed,
2. All reporting, including Actual Allowable Cost Reports,
3. Ad hoc requests for information, when appropriate.

As of the Operational Start Date, the sources for various computerized systems noted above are as follows:

1. **Time Reporting System**
   a. The Project and Portfolio Management (PPM) application is the project management tool CONTRACTOR uses to manage project planning which includes work plan task management. Actual hours are applied to the work plan through timesheet entry. The purpose of PPM is to give decision makers the ability to take action, reprioritize demands, apply additional resources, and maneuver change to maintain focus.
   b. CONTRACTOR will use the State's PPM system to capture and report project time charged by functional area.
   c. The source of project actual time data in PPM is derived from timesheet data submitted by project team members for work performed.
   d. PPM system is used by all resources that charge time to the Agreement, regardless of their affiliation as an Employee or a Subcontractor.

e. PPM timesheet entry and reporting has the following characteristics:
   i. PPM timesheets are submitted twice per month via two timesheet periods, one that accounts for time charged during the 1st through the 15th and one that accounts for time charged from the 16th through the end of the month.
   ii. CONTRACTOR uses prior period adjustments (PPAs) to correct time entries made in the past if necessary. The principle is to reflect time in PPM aligned with when the work is performed.
   iii. CONTRACTOR uses contract year to date reporting, which neutralizes the variability of individual time periods caused by the PPAs.
   iv. CONTRACTOR also captures Employee time in the Corporate Accounting System, and CONTRACTOR reconciles PPM and the Corporate Accounting System, as necessary.
   v. Employees and Subcontractors enter time only into PPM, based on the hours worked. No other project costs are recorded into PPM.
   vi. Employees and Subcontractors enter time into PPM according, but not limited, to the following categories, which will be finalized during the Transition:
      (1) Functional areas
      (2) Amendments
      (3) Contract specific training
      (4) Employee engagement
      (5) Personal time off, including vacation, sick leave, funeral jury, etc.
      (6) Approved holiday
      (7) Excused from office
      (8) Ethics, policy, and other CONTRACTOR-required training
      (9) Recruiting

      Note that only items (1) through (4) above are included in salaries and Subcontractor costs in the Actual Allowable Cost Reports. Other time is for CONTRACTOR to use for internal purposes.

f. PPM timesheet entry and reporting has the following controls:
   i. The ability to charge time to a task in a PPM timesheet is controlled by the Program Management Office and/or the Project Manager of a Change Order/Amendment.
   ii. CONTRACTOR will validate timesheet compliance for timely submission via exception reporting.
   iii. Supervisors are responsible for the timeliness and accuracy of timesheet data for team members in their span of control.

2. **Corporate Accounting System**
   a. CONTRACTOR'S SAP system ("Corporate Accounting System") is used to manage CONTRACTOR's internal financial records of the Agreement
   b. The Corporate Accounting System is the source of Activity Rate for each Employee.
   c. **Activity Rate** is the cost per hour of an Employee, inclusive of both Salary and Fringe Benefits.

CONTRACTOR uses the following manuals and other paper-based items to meet the requirements of the Accounting System:

1. FCS provides the reference for the CONTRACTOR to use to manage to the financial requirements of the Agreement.
2. CPM provides the guidelines for how costs will be recorded and reported, including but not limited to, tenets related to whether costs incurred are allowable, allocable, and Reasonable, in accordance with Exhibit C.
3. The Agreement and its pricing exhibits provide guidance for invoicing.
4. Subcontractor agreements provide guidance for paying Subcontractors, as well as recording Direct Costs into CONTRACTOR financial reports and tools.

5. Third party invoices provide volume and cost inputs used for payments to third parties, for input for unit-based variable billings to HHSC, and for recording Direct Costs into CONTRACTOR financial reports and tools.
6. Actual receipts provide audit support and input for recording Direct Costs into CONTRACTOR financial reports and tools.

II. Accounting for Direct Costs

Direct Costs are defined in the CPM. Direct Costs are recorded and reported in accordance with FCS - 0023 and FCS - 0024.

As FCS - 0024 specifies the Direct Costs categories required in CONTRACTOR's financial reporting, the following sections provide key information related to each Direct Cost category:

1. Description, as it pertains to the Agreement
2. Special stipulations and/or requirements, per the Agreement
3. Source(s) of information
4. Calculations required to determine the Direct Cost amount
5. Other pertinent information

Salaries + Fringe Benefit Rate

1. Description:
    a. Represent the total compensation of Employees to fulfill the Agreement.
    b. Fringe benefits are Directly Associated Costs related to salaries.
    c. Reporting reflects the aggregate salaries and aggregate fringe benefits for all Employees for the functional area or combined functional areas. Salaries and fringe benefits for individual Employees are not included in financial reporting or for ad-hoc inquiries. For clarity, the Fringe Benefits Rate represents the average fringe benefits for all Employees. Individuals will have varying fringe benefits, based on their individual situations.

2. Special stipulations and/or requirements:
    a. Charges to the Agreement for salaries will be based on payrolls documented in accordance with generally accepted practice of the unit and approved by a responsible official(s) of the CONTRACTOR.
    b. No further documentation is required for the salaries of Employees who work in a single indirect cost activity.
    c. Where Employees are expected to work solely on this Agreement, charges for their salaries will be supported by periodic certifications that the Employees worked solely on that contract for the hours in the time period covered by the certification. These certifications will be prepared at least semi-annually and will be signed by the Employee or supervisory official having first-hand knowledge of the work performed by the Employee. Sign-off may occur electronically.
    d. Where Employees work on multiple activities, a distribution of their salaries will be supported by personnel activity reports or equivalent documentation that meets the standards in the Cost Principles Manual unless a substitute system has been reviewed in advance by HHSC and will be subject to audit. Documentary support will be required where Employees work on more than one activity within the CONTRACTOR.
    e. Personnel activity reports or equivalent documentation must meet the following

standards:

i. They must reflect an after-the-fact distribution of the actual activity of each Employee,

ii. They must account for the total activity, for which each Employee is compensated,

iii. They must be prepared at least monthly and must coincide with one or more pay periods, and

iv. They must be signed by the Employee. Electronic certification by the Employee is sufficient to satisfy this standard.

f. Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to the Agreement but may be used for interim accounting purposes, provided that:

i. The CONTRACTOR's system for establishing the estimates produces reasonable approximations of the activity performed; and

ii. At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made and adjustments to actual costs are recorded.

g. Substitute systems for allocating salaries to the Agreement may be used in place of activity reports. These systems are subject to advance review by HHSC and will be subject to audit.

3. Adjustment to Standard Hours for Exempt Employees
   a. Standard hours represent total work hours for the fiscal year less holidays and Paid Time Off (PTO). Therefore, within a given fiscal year if a resource takes their holidays and all their earned PTO for that fiscal year they will work the standard hours. The Contractor will recover the cost associated with the resource (salary + fringe) once the Allowable Costs reported to the client equals the standard hours.
      i. CONTRACTOR policy allows resources to carry over a portion of their PTO into the next fiscal year.
         1. For example, if a resource took thirteen (13) days of PTO and they had earned twenty-five (25) days then they would have worked an additional 12 days within that fiscal year for a total of 1,920 hours. CONTRACTOR would have effectively recovered the resource's cost once CONTRACTOR reported 1,824 hours. CONTRACTOR then needs to stop reporting hours once the resource hits the threshold or adjust their hours because if CONTRACTOR reported the entire 1,920 hours CONTRACTOR is over recovering.
         2. Another situation arises when a resource rolls onto the project later during the fiscal year. The resource might be new to CONTRACTOR or may have been working on some other project within the company. In these cases, the standard hours will need to be prorated to prevent over recovery.
   b. Adjustments for Overtime
      i. Overtime hours are removed because it is not allowable unless the resource is paid for their overtime hours. If the resource is paid for their overtime, then the cost is reported at the overtime rate which is simply salary at time and a half, there is no fringe in the overtime rate.
   c. Adjustment for Unused PTO

i. CONTRACTOR allows Employees to carry a portion of unused PTO over to the next fiscal year. When a resource takes more PTO than they've accrued in a given fiscal year this creates an opposite situation from what was descried in Section II.3.a. above. Because the resource is taking more PTO than accrued for the fiscal year they will charge less than the standard hours in a year. This will cause us to under recover for that resource.
ii. To determine if a resource has taken additional PTO over and above the standard hours which would result in under-recovery, CONTRACTOR may use specific coding in the Corporate Accounting System to identify these resources.
    1. There is an internal code in the Corporate Accounting System that collects the hours of PTO charged for owned resources. Once the resources are identified CONTRACTOR will be able to determined how many days of PTO a year they accrue based on level and years of service (see table below).
    2. The hours over and above their standard PTO hours will then need to be recovered on a pro-rated basis. To determine the pro-rated amount PPM data can be used to determine how much time was spent on the project throughout the Operational Contract Year.

4. Sources of information:
    a. Activity Rate stored in Corporate Accounting System
    b. Hours recorded in Time Reporting System
    c. Fringe Benefit Rate of 38.37%, per FCS - 0011

5. Calculations:
    a. Because Activity Rate reflects the combined salary and fringe benefits of an Employee, a calculation is required to drive each component for reporting purposes.
    b. The approach for separating is to determine the total cost, calculate the salary portion, and then calculate the fringe benefits portion.
        i. Determine the total cost (salaries + fringe benefits) for the entire population
            1. By individual, hours from the Time Reporting System are multiplied by that individual's assigned Activity Rate to determine the total Salary + Fringe for each Employee
            2. All individual totals are summed to determine the total cost (salaries + fringe benefits) for all Employees
        ii. Calculate the salary portion
            1. Divide total cost (salaries + fringe benefits) by 1.3837
            2. Result is the salary portion, which is reported as Salaries
        iii. Calculate the fringe benefits portion
            1. Multiply the salary portion by 0.3837
            2. Result is the fringe benefits portion, which is reported as Fringe Benefits

Subcontractors and consultants

Staff Augmentation

1. Description: Subcontractors or consultants working in a staff augmentation capacity, who are compensated based on the number of hours they work.

2. Special situations and/or requirements:

    a. Staff augmentation Subcontractors and consultants use the same Time Reporting System as Employees.

    b. Staff augmentation Subcontractors and consultants are included in the personnel

activity reports as described in the *Salaries + Fringe Benefits Rate* section above.

c. Regardless of the timing of billings by staff augmentation Subcontractor or consultant to CONTRACTOR, CONTRACTOR records and reports costs based on time worked per the Time Reporting System, in accordance with GAAP principles.

3. Sources of information:
   a. Hourly rate in the Subcontractor or consultant contract with CONTRACTOR
   b. Hours recorded in the Time Reporting System

4. Calculations:
   Hours multiplied by hourly rate from Subcontractor or consultant contract

Unit Based

1. Description: Subcontractors or consultants working in a managed services capacity, who are paid based on their throughput (unit-based).

2. Special situations and/or requirements:
   a. Unit-based Subcontractors and consultants do not use the Time Reporting System.
   b. Unit-based Subcontractors and consultants are not subject to personnel activity reports.
   c. Regardless of the timing of billings by unit-based Subcontractor or consultant to CONTRACTOR, CONTRACTOR records and reports costs based on evidence that services were performed. If no specific volume evidence exists, an accrual will be made based on the best available information and will be trued-up when volume evidence becomes available.

3. Sources of information:
   a. Units as submitted via invoicing or reporting from Subcontractor or consultant to CONTRACTOR
   b. Unit rate from contract between Subcontractor or consultant and CONTRACTOR

4. Calculations:
   Units multiplied by unit rate from contract between Subcontractor or consultant and CONTRACTOR

5. Verification:
   a. The Contractor receives an invoice from each vendor including the numbers of units delivered.
   b. Backup reports are included to substantiate the number of units invoiced to CONTRACTOR.
   c. Vendor Management validates that the units included in the report are valid.
   d. The Contractor provides an electronic backup of the report to the State.

Fixed Price

1. Description: Subcontractors or consultants working in a managed services capacity, who are paid based on a fixed price.

2. Special situations and/or requirements:

a. Fixed price Subcontractors and consultants do not use the Time Reporting System.

b. Fixed price Subcontractors and consultants are not subject to personnel activity reports.

c. Regardless of the timing of billings by fixed price Subcontractor or consultant to CONTRACTOR, CONTRACTOR records and reports costs based on evidence that services were performed. If no specific volume evidence exists, an accrual will be made based on the best available information and will be trued-up when volume evidence becomes available.

3. Sources of information:
   Fixed price from contract between Subcontractor or consultant and CONTRACTOR

Other Non Pass Through Expenses

1. Description: Various costs directly incurred by the CONTRACTOR, but not including salaries, Subcontractors, or Pass-Through Expenses. Other Direct Costs can include, but are not limited to, Employee, Subcontractor, and consultant travel.

2. Special situations and/or requirements
   a. All Employees, Subcontractors, and consultants are subject to the travel standards included in the Travel Policy section of this Accounting Policy Manual.
   b. Travel during the Transition Period is not subject to this APM.

3. Sources of information:
   Invoices and receipts for purchases

Pass-Through Expenses

1. Description: Costs for postage/delivery, facilities, printing, telecom, and hardware/software incurred by the CONTRACTOR.

2. Special situations and/or requirements
   a. Only certain Pass-Through Expenses, in accordance with Exhibit C, Section 7, are included in the Actual Allowable Cost Reports and in the Retrospective Cost Settlement and Productivity Share Determination processes.
   b. Per Exhibit C, Section 7, such Pass-Through Expenses are:
      i. All postage/delivery costs directly related to the operation of the Agreement;
      ii. Office rent (including lease pass-through expenses);
      iii. All printing costs including provider manuals, handbooks, bulletins, and similar;
      iv. All telecommunication lines, including local lines, toll-free lines, electronic communications lines, fiber optic lines, cell phones, Internet connections, etc.; and
      v. Other Pass-Through Expenses agreed by the Parties
   c. Costs for hardware and software capital, licenses, and maintenance will not be included in the Actual Allowable Cost Reports.

3. Sources of information:
   Invoices and receipts for purchases

III. Accounting for Indirect Costs

Indirect Costs are defined in the CPM. Indirect Costs are recorded and reported in accordance with FCS - 0007, FCS - 0009, FCS - 0011, FCS - 0014 and FCS - 0023.

As FCS - 0011 and the CPM specify, the CONTRACTOR will apply two indirect costs rates to the Actual Allowable Cost Report as follows:

1. Common Support Overhead Rate of 10.47%
   Applied to all salaries and fringe benefits
2. Indirect Rate of 32.50%
   Applied to all salaries, fringe benefits, Subcontractors, consultants, travel, and other non pass through expenses

IV. Accounting for Administrative Service Fee

Administrative Service Fee Rate is 16.0036%, as set forth in the Agreement and FCS - 0011.

The CONTRACTOR will calculate the Administrative Service Fees for the Actual Allowable Cost Report by applying the Administrative Service Fee Rate to salaries, fringe benefits, Subcontractors, consultants, travel, other non pass through expenses, indirect costs, and common support overhead.

V. Financial Reporting Timing and Approach

1. CONTRACTOR will develop financial reporting for the following purposes:
   a. To satisfy requirements FCS - 0033 and FCS - 0036
   b. To inform CONTRACTOR and HHSC Finance about ongoing costs of the program
   c. To serve as the basis for the Retrospective Cost Settlement at each Operational Contract Year end

2. Report Definitions

a. Actual Allowable Cost Report - monthly

Purpose	Monthly trend of Allowable Costs that build up the total Allowable Costs
Deliver	By the 25th calendar day in the month following the month of service
First report expectation	No later than 25th day of 7th month after contract execution
Frequency	Deliver twelve (12) times per year
Annual RCS Cost Reviews	Monthly reports will not be used for the RCS and Productivity Share Determination process, but will be reviewed by HHSC Finance to gain insights about ongoing costs of the Agreement
HHSC Finance review	Ideally, review and inquiries is complete by 30th calendar day after report delivery, as the next Actual Allowable Cost Report is set to be released

b. Annual Report

Purpose	Annual total of Allowable Costs Primary document for the RCS and Productivity Share Determination process
Deliver	By December 1, following the year of service being reported
First report expectation	No later than December 1, 2018
Frequency	Deliver one (1) time per year
Annual RCS Cost Reviews	Annual report will be used for RCS and Productivity Share Determination process
HHSC Finance review	Target initial review within sixty (60) calendar days after report delivery Target final review within ninety (90) calendar days after report delivery
Annual Report Acceptance Date	Date that HHSC review and CONTRACTOR clarifications and adjustments are complete. This date signals the start of the annual RCS and Productivity Share Determination process.

3. Actual Allowable Cost Report format and content development

   a. Reporting should have a materially similar look as the A-3 Operations Pricing Schedules

   b. Reporting will be provided as follows:
      i. Total (aggregate) costs of the entire Agreement, shown by month, with a YTD total
      ii. Total costs by functional area, shown by month, with a YTD total
      iii. Total costs by program type, shown by month, with a YTD total
      iv. Note: Reporting will not include two views:
         (1) Program type by functional area
         (2) Functional area by program type

   c. Per FCS - 0005, reporting by program type, which will be based on allocation per section V.3.d of this manual.

   d. The allocation methodology used for reporting by program type is identical to the methodology used in the A-3 Operations Pricing Schedules.

   e. Reporting by functional area, as required by FCS - 0033 includes the following:

      i. These identified functional areas (to be confirmed during Transition):
         (1) General Operational Requirements (incl PMO)
         (2) Actuarial Support (ASC)
         (3) Appeals and Complaints Resolution (ACR)
         (4) Call Centers (CCC)
         (5) Claims Processing (CPC)
         (6) Client Eligibility File Maintenance (CEF)
         (7) Client Services
         (8) Electronic Health Records (EHR)
         (9) Eligibility Verification System (EVS)
         (10) Fair Hearings (FHC)
         (11) Financial Management (FIN)
         (12) (no 12th functional area in the A-3 Operational Pricing Schedules)
         (13) Fund Management (FMG)
         (14) Health Insurance Premium Payment (HIPP) and Insurance Premium Payment Assistance (IPAA)
         (15) Management and Administrative Reporting (MAR)
         (16) Medical and Dental Policy (MDP)
         (17) Medically Needy Program (MNP)
         (18) Office of the Attorney General (OAG)
         (19) Prior Authorization and Referral Management (PAC)
         (20) Provider (PRV)
         (21) Reference Data Management (RDM)
         (22) Reporting – Ongoing and Ad Hoc (AHR)
         (23) Surveillance/Utilization Review (SUR)
         (24) Systems (SYS)
         (25) Third Party Liability (TPL)

      ii. Each new Amendment may be reported as its own functional area, as required by the Amendment.

f. Reporting consists of Direct Costs, including but not be limited to salaries, Subcontractors, consultants, travel expenses, and pass-through expenses, as required by FCS - 0012 and FCS - 0024.

g. Costs related to hardware/software purchases, EVV, and contingency fees are not included in the monthly or annual Actual Allowable Cost Reports.

h. Direct Costs, as defined in the Cost Principle Manual, are reported in the time period the cost is incurred and may be amended as prior period adjustments, as necessary.

i. Unallowable Direct Costs, as defined in the Cost Principle Manual, are eliminated from the report and treated as defined in Exhibit C to the Agreement.

j. Indirect Costs, as defined in the Cost Principle Manual, are reported using the allocation rates as required by FCS - 0011

k. Pass-Through Expenses are reported in the time period that the cost is incurred and may be amended as prior period adjustments, as necessary.

4. Report Delivery Specifications

a. Actual Allowable Cost Reports are delivered by CONTRACTOR Finance, and delivered to HHSC Finance via encrypted email to maintain confidentiality of the information

b. Reports will be provided in Excel and as PDFs

c. Reports will be password protected

d. Both HHSC Finance and CONTRACTOR Finance will restrict access to Actual Allowable Cost Reports for confidentiality purposes

e. No vendors shall have access to the Actual Allowable Cost Reports or the data contained therein without the express consent of CONTRACTOR

f. To avoid communication and version control issues, all Actual Allowable Cost Reports will be communicated by HHSC Finance only, and will be communicated to CONTRACTOR Finance only

g. Actual Allowable Cost Reports must use the following standard naming convention to enable appropriate version control and accessibility:
   i. "Actual Allowable Cost Report YYYY-MM," where YYYY-MM represents the year and month being reported
   ii. Example: On November 25, 2017, if CONTRACTOR Finance delivers the report for October 2017, the file name will be "Actual Allowable Cost Report 2017-10.xls"
   iii. Note that CONTRACTOR will also deliver "Actual Allowable Cost Report 2017-10.pdf"

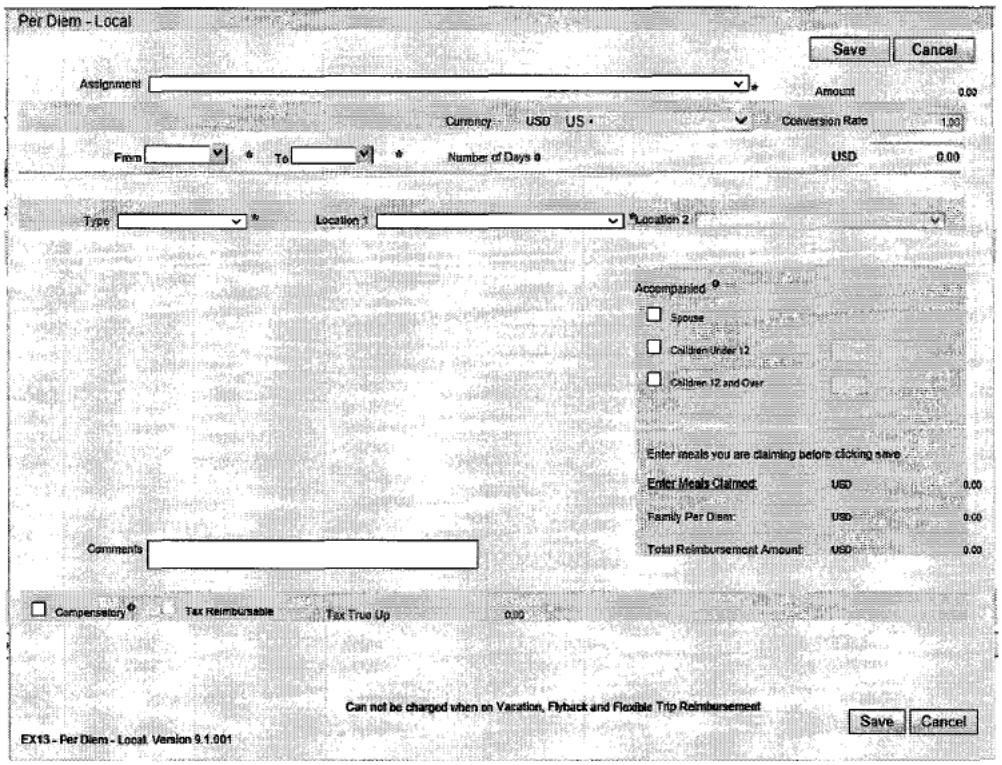
VI. Retrospective Cost Settlement and Productivity Share Determination

CONTRACTOR annual cost reporting will be subject to the Retrospective Cost Settlement and the Productivity Share Determination processes, in accordance with Exhibit C of the Agreement.

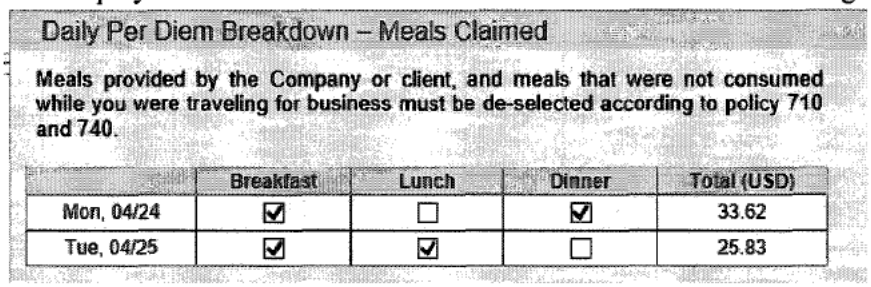
VII. Travel Policy

Employee travel represents the cost of Employees and Subcontractors who must travel to perform the scope of services of the Agreement. All Employees and Subcontractors are subject to the following travel standards:

1. **Overall Standards**
   a. Where any conflict exists between the travel policy of the company of either Employees or Subcontractors, the travel policy in this Accounting Policy Manual prevails, unless company policy requires compliance in excess of what is required in this travel policy; in these such cases, company policy prevails, as the travel policy herein is fully satisfied.
   b. All business travel is to be conducted in the most cost-effective manner in compliance with the provisions of this policy.
   c. All Employees and Subcontractors are responsible for evaluating every trip to understand the expense justification and approval by their supervisor.
   d. "Virtual" alternatives to travel, such as conference calls, web-conferencing, Telepresence and other collaboration technologies should be considered in lieu of travel wherever possible.
2. **Booking Travel**
   a. All business travel arrangements — including air, rail, hotel and rental car reservations — must be booked through the company managed travel program, which includes the designated travel agency and the self-booking tool where available, which will enable access to applicable company-negotiated discounts with preferred suppliers and will also enable the company to locate travelers in the event of an emergency.
   b. Book in advance: Maximize discounts and availability with preferred suppliers by booking all air, rail, hotel and car rental reservations at least seven (7) days in advance.
   c. Use the self-booking tool (SBT): This is the expected method of booking travel in countries where SBTs have been implemented. (Complex itineraries are an approved exception.) Booking online reduces service fee costs significantly.
   d. Book all travel components on the same itinerary: Minimize processing fees incurred by the company by booking air, rail, hotel and/or rental car reservations on the same itinerary, whenever possible.
   e. If plans change, cancel reservations as soon as possible: Maximize the opportunity for refund or reuse of air or rail tickets.
   f. Use company-preferred suppliers: Book with the company's preferred travel suppliers to take full advantage of negotiated discounts and services.
3. **Per Diems**
   a. Per diems may be charged in lieu of individual expense receipts for meals.
   b. Employees are expected to deduct meals from their daily per diem that have been provided to them by the company.
   c. When traveling only for a portion of the day, Employees are expected to deduct meals from their daily per diem for the part of the day that they are not traveling.
   d. Employees perform the following steps in CONTRACTOR's system to record per diems following the requirements:
      i. The Employee enters data into the required fields noted by an asterisk:



ii. The Employee then selects the "Enter Meals Claimed" and the following input box appears:



Daily Per Diem Breakdown – Meals Claimed

Meals provided by the Company or client, and meals that were not consumed while you were traveling for business must be de-selected according to policy 710 and 740.

	Breakfast	Lunch	Dinner	Total (USD)
Mon, 04/24	☑	☐	☑	33.62
Tue, 04/25	☑	☑	☐	25.83

iii. The Employee selects the meals they are claiming (the above selections and costs are illustrative only). As the result of the selections, the appropriate amount is reimbursed to the Employee.

iv. The per-diem rates for a given travel location are established by CONTRACTOR's time and expense reporting system and are not editable by the Employee.

4. Air Travel

a. Air travel should be purchased at the lowest cost consistent with good business practice as defined below.

b. Only economy class is reimbursable for air travel related to the Agreement, unless approved by CONTRACTOR leadership under unusual circumstances. CONTRACTOR will retain approval documentation, as appropriate.

c. Choose the lowest logical airfare available at the time of booking.

d. Choose the lowest fare, regardless of personal airline preference.

e. The use of low-cost carriers is encouraged as an additional cost savings option.

f. Fees charged by the airlines for any incidental items, such as meals or pillows, are covered under per diems and are not reimbursable.

g. Class upgrades purchased from the airlines are not reimbursable.

h. Costs of accompanying family members are not reimbursable.

i. Costs of airline loyalty programs are not reimbursable.

j. Medical exceptions, except for medical emergencies, must be pre-approved by HR.
k. Variances from policies due to emergencies must be reported as soon as practical.

5. Hotel Accommodations

a. Hotel accommodations should be made consistent with the good business practices defined below.
b. Reserve as early as possible to take advantage of company-negotiated rates and to pursue availability of a standard room.
c. Choose a company-preferred hotel property, wherever available. If a company-preferred hotel is not available, an appropriate business class hotel must be booked.
d. The first choice should be a best value hotel, where available, to take advantage of the best combination of low rate and location among the company's preferred hotels.
e. In locations where company hotel volume is insufficient to negotiate a company rate, a preferred chain (first priority) or an approved chain (second priority) should be used if available to take advantage of a company hotel chain discount.
f. Limited-service hotels should be used, wherever available. This type of hotel often includes complimentary Internet and/or breakfast in the room rate, which can be up to 50 percent less than at a full-service property.
g. Luxury hotels, meaning hotels with amenities and/or accommodations that are in excess of the type normally used for business travel (*e.g.*, Four Seasons, St. Regis, Ritz-Carlton, the W), are not allowed.
h. Book the lowest hotel rate available. Reserve the standard room type only.
i. Charges for hotel upgrade rooms or "club floor" rooms are not reimbursable.
j. Avoid "no show" charges by following hotel cancellation policies.
k. Purchases of hotel meals, snacks, and refreshments whether at full service restaurants, hotel bars, or hotel stores are not reimbursable.
l. Purchases for mini-bar items, hotel movies, premium television, or video games are not reimbursable.
m. Costs of hotel loyalty programs are not reimbursable.
n. Hotel receipts are subject to audit. Receipts reflecting purchases for items that are not reimbursable will be scrutinized and may result in disciplinary action.

6. Ground Transportation

a. Employees should use the lowest cost, safe transportation choice when conducting CONTRACTOR business. Safety is always a primary concern, and the selection of transportation should reflect that.
b. When safe and possible, Employees should select public transportation, which also has a positive impact on the environment.
c. Taxi and Standard Car (e.g., Uber, Lyft, etc.) are approved modes of ground transportation.
d. Limousine is not allowed, unless three or more passengers are sharing the limousine.
e. Transportation to/from the airport or parking at the airport is a reimbursable expense, but not both.
f. All car rentals are expected to be arranged with company-preferred suppliers only, utilizing CONTRACTOR's negotiated rates.
g. Rental cars are to be shared when possible and practical.
h. Renting sport utility vehicle (SUV) or similar is allowed with advance CONTRACTOR leadership approval.
i. Renting luxury vehicles is not allowed.
j. Charges for car class upgrades are not reimbursable.
k. Fines for parking or traffic violations are not reimbursable.
l. Costs of rental car loyalty programs are not reimbursable.

7. **Expense Reporting**
   a. All travel expenses should be charged to the project/engagement or sponsoring organization via the appropriate WBS element.
   b. Expenses are audited by the Employee's supervisor, the project/engagement Client Finance Manager (CFM), as well as the audit team, to manage compliance.
   c. Receipts are required for all expenses, except for per diems and as follows:
      i. Receipts are not required for expenses less than $25
      ii. Receipts are not required between $25 and $100, if the charge can be imported from the Employee's American Express account, and it's not in one of the following categories:
         (1) Hotel
         (2) Airfare
         (3) Car Rental
   d. Employees must also submit their business expenses in a timely manner.

VIII. Billing Approach

CONTRACTOR delivers invoices for services according to the provisions included in Exhibit C to the Agreement.

IX. Audits

CONTRACTOR may be subject to audits from the Texas State Auditor's Office (SAO), the federal government, and potentially other governmental authorities. CONTRACTOR will cooperate with these such auditors per FCS - 0030.

EXHIBIT D

Texas Health and Human Services Commission
Texas Medicaid Management Information System Takeover
HHSC Contract # 529-16-0007
Exhibit D-01

Fixed Fees for Transition

	By Key Milestones	Fixed Fee (Transition Months)
1	*Milestone #1 Transition Start Up and Planning*	$ 14,322.08
2	*Milestone #2 Set-up Contract Requirements, Key Measures and Liquidated Damages*	$ 14,322.08
3	*Milestone #3 Create/Revise Deliverables*	$ 56,094.80
4	*Milestone #4 Data Tracking and Review/Document Current State*	$ 32,224.67
5	*Milestone #5 Review/Revise Documentation*	$ 32,224.67
6	*Milestone #6 Conduct Operational Readiness*	$ 41,772.73
7	*Milestone #7 Start-up/Cutover*	$ 23,870.13
8	*Milestone #8 Time Reporting and Direct Labor Tracking*	$ 32,226.44
9	*Milestone #9 Other Direct Cost Tracking*	$ 16,018.44
10	*Milestone #10 Subcontractor Cost tracking*	$ 19,683.40
11	*Milestone #11 Fee Reporting*	$ 44,390.36
Total Fixed Fees		**$ 327,149.81**

Fixed Operational Fees

Month	Contract Period	Core Title XIX	Electronic Health Records (EHR)	Children with Special Health Care Needs Services Program (CSHCN)	Family Planning Title V and XX (FP)	Expanded Primary Health Care program	Primary Health Care program	Long Term Care (LTC)	Medical Transportation Program (MTP)	Healthy Texas Women's Program	Total
Contract Year 1 : August 1, 2017 – August 31, 2018 (13 Months)											
August 2017	Contract Year 1	$ 11,462,276.84	$ 347,092.29	$ 122,341.21	$ 10,651.37	$ 10,651.37	$ 10,651.37	$ 487,459.67	$ 97,837.33	$ 107,801.29	$ 12,656,762.74
September 2017	Contract Year 1	$ 11,462,276.84	$ 347,092.29	$ 122,341.21	$ 10,651.37	$ 10,651.37	$ 10,651.37	$ 487,459.67	$ 97,837.33	$ 107,801.29	$ 12,656,762.74
October 2017	Contract Year 1	$ 11,462,276.84	$ 347,092.29	$ 122,341.21	$ 10,651.37	$ 10,651.37	$ 10,651.37	$ 487,459.67	$ 97,837.33	$ 107,801.29	$ 12,656,762.74
November 2017	Contract Year 1	$ 11,462,276.84	$ 347,092.29	$ 122,341.21	$ 10,651.37	$ 10,651.37	$ 10,651.37	$ 487,459.67	$ 97,837.33	$ 107,801.29	$ 12,656,762.74
December 2017	Contract Year 1	$ 11,462,276.84	$ 347,092.29	$ 122,341.21	$ 10,651.37	$ 10,651.37	$ 10,651.37	$ 487,459.67	$ 97,837.33	$ 107,801.29	$ 12,656,762.74
January 2018	Contract Year 1	$ 11,462,276.84	$ 347,092.29	$ 122,341.21	$ 10,651.37	$ 10,651.37	$ 10,651.37	$ 487,459.67	$ 97,837.33	$ 107,801.29	$ 12,656,762.74
February 2018	Contract Year 1	$ 11,462,276.84	$ 347,092.29	$ 122,341.21	$ 10,651.37	$ 10,651.37	$ 10,651.37	$ 487,459.67	$ 97,837.33	$ 107,801.29	$ 12,656,762.74
March 2018	Contract Year 1	$ 11,462,276.84	$ 347,092.29	$ 122,341.21	$ 10,651.37	$ 10,651.37	$ 10,651.37	$ 487,459.67	$ 97,837.33	$ 107,801.29	$ 12,656,762.74
April 2018	Contract Year 1	$ 11,462,276.84	$ 347,092.29	$ 122,341.21	$ 10,651.37	$ 10,651.37	$ 10,651.37	$ 487,459.67	$ 97,837.33	$ 107,801.29	$ 12,656,762.74
May 2018	Contract Year 1	$ 11,462,276.84	$ 347,092.29	$ 122,341.21	$ 10,651.37	$ 10,651.37	$ 10,651.37	$ 487,459.67	$ 97,837.33	$ 107,801.29	$ 12,656,762.74
June 2018	Contract Year 1	$ 11,462,276.84	$ 347,092.29	$ 122,341.21	$ 10,651.37	$ 10,651.37	$ 10,651.37	$ 487,459.67	$ 97,837.33	$ 107,801.29	$ 12,656,762.74
July 2018	Contract Year 1	$ 11,462,276.84	$ 347,092.29	$ 122,341.21	$ 10,651.37	$ 10,651.37	$ 10,651.37	$ 487,459.67	$ 97,837.33	$ 107,801.29	$ 12,656,762.74
August 2018	Contract Year 1	$ 11,462,276.84	$ 347,092.29	$ 122,341.21	$ 10,651.37	$ 10,651.37	$ 10,651.37	$ 487,459.67	$ 97,837.33	$ 107,801.29	$ 12,656,762.74
Pass Thru Expenses (HW/SW Maintenance, SW License fees and Capital Exp)*		$ 17,114,939.22	$ -	$ 163,748.74	$ 16,600.59	$ 16,600.59	$ 16,600.59	$ 689,818.33	$ -	$ 168,012.65	$ 18,186,320.69
Total Fixed Fees (Contract Year 1)		$ 166,124,538.11	$ 4,512,199.72	$ 1,754,184.51	$ 155,068.42	$ 155,068.42	$ 155,068.42	$ 7,026,794.06	$ 1,271,885.29	$ 1,569,429.42	$ 182,724,236.37

Month	Contract Period	Core Title XIX	Electronic Health Records (EHR)	Children with Special Health Care Needs Services Program (CSHCN)	Family Planning Title V and XX (FP)	Expanded Primary Health Care program	Primary Health Care program	Long Term Care (LTC)	Medical Transportation Program (MTP)	Healthy Texas Women's Program	Total
Contract Year 2 : September 1, 2018 – August 31, 2019 (12 Months)											
September 2018	Contract Year 2	$ 11,626,250.22	$ 347,092.29	$ 123,751.66	$ 10,811.14	$ 10,811.14	$ 10,811.14	$ 487,967.24	$ 100,988.27	$ 109,418.30	$ 12,827,901.38
October 2018	Contract Year 2	$ 11,626,250.22	$ 347,092.29	$ 123,751.66	$ 10,811.14	$ 10,811.14	$ 10,811.14	$ 487,967.24	$ 100,988.27	$ 109,418.30	$ 12,827,901.38
November 2018	Contract Year 2	$ 11,626,250.22	$ 347,092.29	$ 123,751.66	$ 10,811.14	$ 10,811.14	$ 10,811.14	$ 487,967.24	$ 100,988.27	$ 109,418.30	$ 12,827,901.38
December 2018	Contract Year 2	$ 11,626,250.22	$ 347,092.29	$ 123,751.66	$ 10,811.14	$ 10,811.14	$ 10,811.14	$ 487,967.24	$ 100,988.27	$ 109,418.30	$ 12,827,901.38
January 2019	Contract Year 2	$ 11,626,250.22	$ 347,092.29	$ 123,751.66	$ 10,811.14	$ 10,811.14	$ 10,811.14	$ 487,967.24	$ 100,988.27	$ 109,418.30	$ 12,827,901.38
February 2019	Contract Year 2	$ 11,626,250.22	$ 347,092.29	$ 123,751.66	$ 10,811.14	$ 10,811.14	$ 10,811.14	$ 487,967.24	$ 100,988.27	$ 109,418.30	$ 12,827,901.38
March 2019	Contract Year 2	$ 11,626,250.22	$ 347,092.29	$ 123,751.66	$ 10,811.14	$ 10,811.14	$ 10,811.14	$ 487,967.24	$ 100,988.27	$ 109,418.30	$ 12,827,901.38
April 2019	Contract Year 2	$ 11,626,250.22	$ 347,092.29	$ 123,751.66	$ 10,811.14	$ 10,811.14	$ 10,811.14	$ 487,967.24	$ 100,988.27	$ 109,418.30	$ 12,827,901.38
May 2019	Contract Year 2	$ 11,626,250.22	$ 347,092.29	$ 123,751.66	$ 10,811.14	$ 10,811.14	$ 10,811.14	$ 487,967.24	$ 100,988.27	$ 109,418.30	$ 12,827,901.38
June 2019	Contract Year 2	$ 11,626,250.22	$ 347,092.29	$ 123,751.66	$ 10,811.14	$ 10,811.14	$ 10,811.14	$ 487,967.24	$ 100,988.27	$ 109,418.30	$ 12,827,901.38
July 2019	Contract Year 2	$ 11,626,250.22	$ 347,092.29	$ 123,751.66	$ 10,811.14	$ 10,811.14	$ 10,811.14	$ 487,967.24	$ 100,988.27	$ 109,418.30	$ 12,827,901.38
August 2019	Contract Year 2	$ 11,626,250.22	$ 347,092.29	$ 123,751.66	$ 10,811.14	$ 10,811.14	$ 10,811.14	$ 487,967.24	$ 100,988.27	$ 109,418.30	$ 12,827,901.38
Pass Thru Expenses (HW/SW Maintenance, SW License fees and Capital Exp)*		$ 14,234,921.82	$ -	$ 136,193.91	$ 13,807.12	$ 13,807.12	$ 13,807.12	$ 573,739.11	$ -	$ 139,740.31	$ 15,126,016.51
Total Fixed Fees (Contract Year 2)		$ 153,749,924.45	$ 4,165,107.43	$ 1,621,213.80	$ 143,540.76	$ 143,540.76	$ 143,540.76	$ 6,429,345.96	$ 1,211,859.24	$ 1,452,759.96	$ 169,060,833.12

Month	Contract Period	Core Title XIX	Electronic Health Records (EHR)	Children with Special Health Care Needs Services Program (CSHCN)	Family Planning Title V and XX (FP)	Expanded Primary Health Care program	Primary Health Care program	Long Term Care (LTC)	Medical Transportation Program (MTP)	Healthy Texas Women's Program	Total
Contract Year 3 : September 1, 2019 – August 31, 2020 (12 Months)											
September 2019	Contract Year 3	$ 11,794,141.16	$ 347,092.29	$ 125,188.36	$ 10,974.69	$ 10,974.69	$ 10,974.69	$ 501,323.19	$ 76,420.37	$ 111,073.58	$ 12,988,162.99
October 2019	Contract Year 3	$ 11,794,141.16	$ 347,092.29	$ 125,188.36	$ 10,974.69	$ 10,974.69	$ 10,974.69	$ 501,323.19	$ 76,420.37	$ 111,073.58	$ 12,988,162.99
November 2019	Contract Year 3	$ 11,794,141.16	$ 347,092.29	$ 125,188.36	$ 10,974.69	$ 10,974.69	$ 10,974.69	$ 501,323.19	$ 76,420.37	$ 111,073.58	$ 12,988,162.99
December 2019	Contract Year 3	$ 11,794,141.16	$ 347,092.29	$ 125,188.36	$ 10,974.69	$ 10,974.69	$ 10,974.69	$ 501,323.19	$ 76,420.37	$ 111,073.58	$ 12,988,162.99
January 2020	Contract Year 3	$ 11,794,141.16	$ 347,092.29	$ 125,188.36	$ 10,974.69	$ 10,974.69	$ 10,974.69	$ 501,323.19	$ 76,420.37	$ 111,073.58	$ 12,988,162.99
February 2020	Contract Year 3	$ 11,794,141.16	$ 347,092.29	$ 125,188.36	$ 10,974.69	$ 10,974.69	$ 10,974.69	$ 501,323.19	$ 76,420.37	$ 111,073.58	$ 12,988,162.99
March 2020	Contract Year 3	$ 11,794,141.16	$ 347,092.29	$ 125,188.36	$ 10,974.69	$ 10,974.69	$ 10,974.69	$ 501,323.19	$ 76,420.37	$ 111,073.58	$ 12,988,162.99
April 2020	Contract Year 3	$ 11,794,141.16	$ 347,092.29	$ 125,188.36	$ 10,974.69	$ 10,974.69	$ 10,974.69	$ 501,323.19	$ 76,420.37	$ 111,073.58	$ 12,988,162.99
May 2020	Contract Year 3	$ 11,794,141.16	$ 347,092.29	$ 125,188.36	$ 10,974.69	$ 10,974.69	$ 10,974.69	$ 501,323.19	$ 76,420.37	$ 111,073.58	$ 12,988,162.99
June 2020	Contract Year 3	$ 11,794,141.16	$ 347,092.29	$ 125,188.36	$ 10,974.69	$ 10,974.69	$ 10,974.69	$ 501,323.19	$ 76,420.37	$ 111,073.58	$ 12,988,162.99
July 2020	Contract Year 3	$ 11,794,141.16	$ 347,092.29	$ 125,188.36	$ 10,974.69	$ 10,974.69	$ 10,974.69	$ 501,323.19	$ 76,420.37	$ 111,073.58	$ 12,988,162.99
August 2020	Contract Year 3	$ 11,794,141.16	$ 347,092.29	$ 125,188.36	$ 10,974.69	$ 10,974.69	$ 10,974.69	$ 501,323.19	$ 76,420.37	$ 111,073.58	$ 12,988,162.99
Pass Thru Expenses (HW/SW Maintenance, SW License fees and Capital Exp)*		$ 13,774,569.82	$ -	$ 131,789.45	$ 13,360.60	$ 13,360.60	$ 13,360.60	$ 555,184.61	$ -	$ 135,221.16	$ 14,636,846.85
Total Fixed Fees (Contract Year 3)		$ 155,304,263.69	$ 4,165,107.43	$ 1,634,049.72	$ 145,056.84	$ 145,056.84	$ 145,056.84	$ 6,571,062.84	$ 917,044.44	$ 1,468,104.12	$ 170,494,802.76

Contract Years 1 - 3 : August 1, 2017 – August 31, 2020 (37 Months)	Core Title XIX	Electronic Health Records (EHR)	Children with Special Health Care Needs Services Program (CSHCN)	Family Planning Title V and XX (FP)	Expanded Primary Health Care program	Primary Health Care program	Long Term Care (LTC)	Medical Transportation Program (MTP)	Healthy Texas Women's Program	TOTAL
Grand-Total Fixed Fees (Contract Years 1, 2, 3)	$ 475,178,726.25	$ 12,842,414.68	$ 5,009,448.03	$ 443,666.02	$ 443,666.02	$ 443,666.02	$ 20,027,202.86	$ 3,400,788.97	$ 4,490,293.50	$ 522,279,872.25

* - Hardware/software maintenance, software licensing fees and capital expenditures will be invoiced based on actual expenses incurred.

Variable Baseline Fees *(Related to ARC/RRC baseline Volume)*

Month	Contract Period	Claims Processing ARC/RRC	Provider Enrollment ARC/RRC	Prior Authorization ARC/RRC	LTC ARC/RRC	Provider Call ARC/RRC	Client & MCT Call ARC/RRC	Total
August 2017	Contract Year 1	$ 202,734.77	$ 370,325.43	$ 746,455.35	$ 161,893.59	$ 370,471.86	$ 216,888.49	$ 2,068,769.50
September 2017	Contract Year 1	$ 202,734.77	$ 370,554.94	$ 746,455.35	$ 161,893.59	$ 370,471.86	$ 216,888.49	$ 2,068,999.01
October 2017	Contract Year 1	$ 202,734.77	$ 370,554.94	$ 746,455.35	$ 161,893.59	$ 370,471.86	$ 216,888.49	$ 2,068,999.01
November 2017	Contract Year 1	$ 202,734.77	$ 370,554.94	$ 746,455.35	$ 161,893.59	$ 370,471.86	$ 216,888.49	$ 2,068,999.01
December 2017	Contract Year 1	$ 204,625.73	$ 381,491.23	$ 766,699.87	$ 166,689.63	$ 381,788.19	$ 223,570.52	$ 2,124,865.18
January 2018	Contract Year 1	$ 204,625.73	$ 381,491.23	$ 766,699.87	$ 166,689.63	$ 381,788.19	$ 223,570.52	$ 2,124,865.18
February 2018	Contract Year 1	$ 204,625.73	$ 383,104.28	$ 766,699.87	$ 166,689.63	$ 381,788.19	$ 223,570.52	$ 2,126,478.23
March 2018	Contract Year 1	$ 204,625.73	$ 383,104.28	$ 766,699.87	$ 166,689.63	$ 381,788.19	$ 223,570.52	$ 2,126,478.23
April 2018	Contract Year 1	$ 204,625.73	$ 383,104.28	$ 766,699.87	$ 166,689.63	$ 381,788.19	$ 223,570.52	$ 2,126,478.23
May 2018	Contract Year 1	$ 204,625.73	$ 383,104.28	$ 766,699.87	$ 166,689.63	$ 381,788.19	$ 223,570.52	$ 2,126,478.23
June 2018	Contract Year 1	$ 204,625.73	$ 383,104.28	$ 766,699.87	$ 166,689.63	$ 381,788.19	$ 223,570.52	$ 2,126,478.23
July 2018	Contract Year 1	$ 204,625.73	$ 383,104.28	$ 766,699.87	$ 166,689.63	$ 381,788.19	$ 223,570.52	$ 2,126,478.23
August 2018	Contract Year 1	$ 204,933.89	$ 383,116.49	$ 766,699.87	$ 166,689.63	$ 381,788.19	$ 223,570.52	$ 2,126,798.60
Total Contract Year 1		**$ 2,652,878.83**	**$ 4,926,714.91**	**$ 9,886,120.21**	**$ 2,147,781.06**	**$ 4,917,981.18**	**$ 2,879,688.65**	**$ 27,411,164.85**

Contract Year 1 : August 1, 2017 – August 31, 2018 (13 Months)

Month	Contract Period	Claims Processing ARC/RRC	Provider Enrollment ARC/RRC	Prior Authorization ARC/RRC	LTC ARC/RRC	Provider Call ARC/RRC	Client & MCT Call ARC/RRC	Total
September 2018	Contract Year 2	$ 203,871.56	$ 379,733.74	$ 743,182.70	$ 166,669.78	$ 372,168.67	$ 221,182.72	$ 2,086,809.17
October 2018	Contract Year 2	$ 203,871.56	$ 379,733.74	$ 743,182.70	$ 166,669.78	$ 372,168.67	$ 221,182.72	$ 2,086,809.17
November 2018	Contract Year 2	$ 203,871.56	$ 379,733.74	$ 743,182.70	$ 166,669.78	$ 372,168.67	$ 221,182.72	$ 2,086,809.17
December 2018	Contract Year 2	$ 205,755.45	$ 390,760.23	$ 762,992.44	$ 171,529.50	$ 383,343.93	$ 227,881.16	$ 2,142,262.71
January 2019	Contract Year 2	$ 205,755.45	$ 390,760.23	$ 762,992.44	$ 171,529.50	$ 383,343.93	$ 227,881.16	$ 2,142,262.71
February 2019	Contract Year 2	$ 205,755.45	$ 390,760.23	$ 762,992.44	$ 171,529.50	$ 383,343.93	$ 227,881.16	$ 2,142,262.71
March 2019	Contract Year 2	$ 205,755.45	$ 390,760.23	$ 762,992.44	$ 171,529.50	$ 383,343.93	$ 227,881.16	$ 2,142,262.71
April 2019	Contract Year 2	$ 205,755.45	$ 390,760.23	$ 762,992.44	$ 171,529.50	$ 383,343.93	$ 227,881.16	$ 2,142,262.71
May 2019	Contract Year 2	$ 205,755.45	$ 390,760.23	$ 762,992.44	$ 171,529.50	$ 383,343.93	$ 227,881.16	$ 2,142,262.71
June 2019	Contract Year 2	$ 205,755.45	$ 390,760.23	$ 762,992.44	$ 171,529.50	$ 383,343.93	$ 227,881.16	$ 2,142,262.71
July 2019	Contract Year 2	$ 205,755.45	$ 390,760.23	$ 762,992.44	$ 171,529.50	$ 383,343.93	$ 227,881.16	$ 2,142,262.71
August 2019	Contract Year 2	$ 206,072.86	$ 390,772.80	$ 762,992.44	$ 171,529.50	$ 383,343.93	$ 227,881.16	$ 2,142,592.69
Total Contract Year 2		**$ 2,463,731.16**	**$ 4,656,055.89**	**$ 9,096,480.05**	**$ 2,043,774.87**	**$ 4,566,601.35**	**$ 2,714,478.61**	**$ 25,541,121.92**

Contract Year 2 : September 1, 2018 – August 31, 2019 (12 Months)

Month	Contract Period	Claims Processing ARC/RRC	Provider Enrollment ARC/RRC	Prior Authorization ARC/RRC	LTC ARC/RRC	Provider Call ARC/RRC	Client & MCT Call ARC/RRC	Total
September 2019	Contract Year 3	$ 204,759.45	$ 387,680.86	$ 740,561.12	$ 171,509.65	$ 372,731.65	$ 225,421.05	$ 2,102,663.77
October 2019	Contract Year 3	$ 204,759.45	$ 387,680.86	$ 740,561.12	$ 171,509.65	$ 372,731.65	$ 225,421.05	$ 2,102,663.77
November 2019	Contract Year 3	$ 204,759.45	$ 387,680.86	$ 740,561.12	$ 171,509.65	$ 372,731.65	$ 225,421.05	$ 2,102,663.77
December 2019	Contract Year 3	$ 206,660.62	$ 398,946.32	$ 760,300.10	$ 176,516.55	$ 383,923.96	$ 232,247.84	$ 2,158,595.39
January 2020	Contract Year 3	$ 206,660.62	$ 398,946.32	$ 760,300.10	$ 176,516.55	$ 383,923.96	$ 232,247.84	$ 2,158,595.39
February 2020	Contract Year 3	$ 206,660.62	$ 398,946.32	$ 760,300.10	$ 176,516.55	$ 383,923.96	$ 232,247.84	$ 2,158,595.39
March 2020	Contract Year 3	$ 206,660.62	$ 398,946.32	$ 760,300.10	$ 176,516.55	$ 383,923.96	$ 232,247.84	$ 2,158,595.39
April 2020	Contract Year 3	$ 206,660.62	$ 398,946.32	$ 760,300.10	$ 176,516.55	$ 383,923.96	$ 232,247.84	$ 2,158,595.39
May 2020	Contract Year 3	$ 206,660.62	$ 398,946.32	$ 760,300.10	$ 176,516.55	$ 383,923.96	$ 232,247.84	$ 2,158,595.39
June 2020	Contract Year 3	$ 206,660.62	$ 398,946.32	$ 760,300.10	$ 176,516.55	$ 383,923.96	$ 232,247.84	$ 2,158,595.39
July 2020	Contract Year 3	$ 206,660.62	$ 398,946.32	$ 760,300.10	$ 176,516.55	$ 383,923.96	$ 232,247.84	$ 2,158,595.39
August 2020	Contract Year 3	$ 206,987.55	$ 398,959.27	$ 760,300.10	$ 176,516.55	$ 383,923.96	$ 232,247.84	$ 2,158,935.27
Total Contract Year 3		**$ 2,474,550.85**	**$ 4,753,572.42**	**$ 9,064,384.30**	**$ 2,103,177.87**	**$ 4,573,510.56**	**$ 2,766,493.72**	**$ 25,735,689.71**

Contract Year 3 : September 1, 2019 – August 31, 2020 (12 Months)

	Claims Processing ARC/RRC	Provider Enrollment ARC/RRC	Prior Authorization ARC/RRC	LTC ARC/RRC	Provider Call ARC/RRC	Client & MCT Call ARC/RRC	TOTAL
Grand-Total Variable Baseline Fees (Contract Years 1, 2, 3)	**$ 7,591,160.83**	**$ 14,336,343.22**	**$ 28,046,984.56**	**$ 6,294,733.81**	**$ 14,058,093.09**	**$ 8,360,660.98**	**$ 78,687,976.49**

Contract Year s 1 - 3 : August 1, 2017 – August 31, 2020 (37 Months)

Claims Processing ARCs/RRCs Table

Claims Processing ARC/RRC					Contract Year 1												
Effect	**% volume above the baseline***	**Volume**			**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**
Reprice	20%	> 210,000															
ARC 3	15% to 19.9%	201,250	-	209,999	$32,884.18	$32,884.18	$32,884.18	$32,884.18	$32,884.18	$32,884.18	$32,884.18	$32,884.18	$32,884.18	$32,884.18	$32,884.18	$32,884.18	$32,884.18
ARC 2	10% to 14.9%	192,500	-	201,249	$21,922.79	$21,922.79	$21,922.79	$21,922.79	$21,922.79	$21,922.79	$21,922.79	$21,922.79	$21,922.79	$21,922.79	$21,922.79	$21,922.79	$21,922.79
ARC 1	5% to 9.9%	183,750	-	192,499	$10,961.39	$10,961.39	$10,961.39	$10,961.39	$10,961.39	$10,961.39	$10,961.39	$10,961.39	$10,961.39	$10,961.39	$10,961.39	$10,961.39	$10,961.39
Deadband	0% to 4.9%	175,001	-	183,749													
Variable Baseline		**175,000**			$202,734.77	$202,734.77	$202,734.77	$202,734.77	$204,625.73	$204,625.73	$204,625.73	$204,625.73	$204,625.73	$204,625.73	$204,625.73	$204,625.73	$204,933.89
Deadband	-0% to -4.9%	174,999	-	166,249													
RRC 1	-5% to -9.9%	166,250	-	157,499	-$10,961.39	-$10,961.39	-$10,961.39	-$10,961.39	-$10,961.39	-$10,961.39	-$10,961.39	-$10,961.39	-$10,961.39	-$10,961.39	-$10,961.39	-$10,961.39	-$10,961.39
RRC 2	-10% to -14.9%	157,500	-	148,749	-$21,922.79	-$21,922.79	-$21,922.79	-$21,922.79	-$21,922.79	-$21,922.79	-$21,922.79	-$21,922.79	-$21,922.79	-$21,922.79	-$21,922.79	-$21,922.79	-$21,922.79
RRC 3	-15% to -19.9%	148,750	-	140,001	-$32,884.18	-$32,884.18	-$32,884.18	-$32,884.18	-$32,884.18	-$32,884.18	-$32,884.18	-$32,884.18	-$32,884.18	-$32,884.18	-$32,884.18	-$32,884.18	-$32,884.18
Reprice	-20%	< 140,000															
Variable Baseline FTE's					36.0	36.0	36.0	36.0	36.0	36.0	36.0	36.0	36.0	36.0	36.0	36.0	36.0

Claims Processing ARC/RRC					Contract Year 2											
Effect	**% volume above the baseline***	**Volume**			**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**
Reprice	20%	> 210,000														
ARC 3	15% to 19.9%	201,250	-	209,999	$33,541.87	$33,541.87	$33,541.87	$33,541.87	$33,541.87	$33,541.87	$33,541.87	$33,541.87	$33,541.87	$33,541.87	$33,541.87	$33,541.87
ARC 2	10% to 14.9%	192,500	-	201,249	$22,361.24	$22,361.24	$22,361.24	$22,361.24	$22,361.24	$22,361.24	$22,361.24	$22,361.24	$22,361.24	$22,361.24	$22,361.24	$22,361.24
ARC 1	5% to 9.9%	183,750	-	192,499	$11,180.62	$11,180.62	$11,180.62	$11,180.62	$11,180.62	$11,180.62	$11,180.62	$11,180.62	$11,180.62	$11,180.62	$11,180.62	$11,180.62
Deadband	0% to 4.9%	175,001	-	183,749												
Variable Baseline		**175,000**			$203,871.56	$203,871.56	$203,871.56	$205,755.45	$205,755.45	$205,755.45	$205,755.45	$205,755.45	$205,755.45	$205,755.45	$205,755.45	$206,072.86
Deadband	-0% to -4.9%	174,999	-	166,249												
RRC 1	-5% to -9.9%	166,250	-	157,499	-$11,180.62	-$11,180.62	-$11,180.62	-$11,180.62	-$11,180.62	-$11,180.62	-$11,180.62	-$11,180.62	-$11,180.62	-$11,180.62	-$11,180.62	-$11,180.62
RRC 2	-10% to -14.9%	157,500	-	148,749	-$22,361.24	-$22,361.24	-$22,361.24	-$22,361.24	-$22,361.24	-$22,361.24	-$22,361.24	-$22,361.24	-$22,361.24	-$22,361.24	-$22,361.24	-$22,361.24
RRC 3	-15% to -19.9%	148,750	-	140,001	-$33,541.87	-$33,541.87	-$33,541.87	-$33,541.87	-$33,541.87	-$33,541.87	-$33,541.87	-$33,541.87	-$33,541.87	-$33,541.87	-$33,541.87	-$33,541.87
Reprice	-20%	< 140,000														
Variable Baseline FTE's					35.0	35.0	35.0	35.0	35.0	35.0	35.0	35.0	35.0	35.0	35.0	35.0

Claims Processing ARC/RRC					Contract Year 3											
Effect	**% volume above the baseline***	**Volume**			**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**
Reprice	20%	> 210,000														
ARC 3	15% to 19.9%	201,250	-	209,999	$34,199.55	$34,199.55	$34,199.55	$34,199.55	$34,199.55	$34,199.55	$34,199.55	$34,199.55	$34,199.55	$34,199.55	$34,199.55	$34,199.55
ARC 2	10% to 14.9%	192,500	-	201,249	$22,799.70	$22,799.70	$22,799.70	$22,799.70	$22,799.70	$22,799.70	$22,799.70	$22,799.70	$22,799.70	$22,799.70	$22,799.70	$22,799.70
ARC 1	5% to 9.9%	183,750	-	192,499	$11,399.85	$11,399.85	$11,399.85	$11,399.85	$11,399.85	$11,399.85	$11,399.85	$11,399.85	$11,399.85	$11,399.85	$11,399.85	$11,399.85
Deadband	0% to 4.9%	175,001	-	183,749												
Variable Baseline		**175,000**			$204,759.45	$204,759.45	$204,759.45	$206,660.62	$206,660.62	$206,660.62	$206,660.62	$206,660.62	$206,660.62	$206,660.62	$206,660.62	$206,987.55
Deadband	-0% to -4.9%	174,999	-	166,249												
RRC 1	-5% to -9.9%	166,250	-	157,499	-$11,399.85	-$11,399.85	-$11,399.85	-$11,399.85	-$11,399.85	-$11,399.85	-$11,399.85	-$11,399.85	-$11,399.85	-$11,399.85	-$11,399.85	-$11,399.85
RRC 2	-10% to -14.9%	157,500	-	148,749	-$22,799.70	-$22,799.70	-$22,799.70	-$22,799.70	-$22,799.70	-$22,799.70	-$22,799.70	-$22,799.70	-$22,799.70	-$22,799.70	-$22,799.70	-$22,799.70
RRC 3	-15% to -19.9%	148,750	-	140,001	-$34,199.55	-$34,199.55	-$34,199.55	-$34,199.55	-$34,199.55	-$34,199.55	-$34,199.55	-$34,199.55	-$34,199.55	-$34,199.55	-$34,199.55	-$34,199.55
Reprice	-20%	< 140,000														
Variable Baseline FTE's					34.0	34.0	34.0	34.0	34.0	34.0	34.0	34.0	34.0	34.0	34.0	34.0

Provider Calls ARCs/RRCs Table

Provider Call ARC/RRC					Contract Year 1												
Effect	**% volume above the baseline***	**Volume**			**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**
Reprice	25%	> 108,536															
ARC 4	20% to 24.9%	104,195	-	108,535	$102,088.21	$102,088.21	$102,088.21	$102,088.21	$102,088.21	$102,088.21	$102,088.21	$102,088.21	$102,088.21	$102,088.21	$102,088.21	$102,088.21	$102,088.21
ARC 3	15% to 19.9%	99,854	-	104,194	$76,566.16	$76,566.16	$76,566.16	$76,566.16	$76,566.16	$76,566.16	$76,566.16	$76,566.16	$76,566.16	$76,566.16	$76,566.16	$76,566.16	$76,566.16
ARC 2	10% to 14.9%	95,512	-	99,853	$51,044.10	$51,044.10	$51,044.10	$51,044.10	$51,044.10	$51,044.10	$51,044.10	$51,044.10	$51,044.10	$51,044.10	$51,044.10	$51,044.10	$51,044.10
ARC 1	5% to 9.9%	91,171	-	95,511	$25,522.05	$25,522.05	$25,522.05	$25,522.05	$25,522.05	$25,522.05	$25,522.05	$25,522.05	$25,522.05	$25,522.05	$25,522.05	$25,522.05	$25,522.05
Deadband	0% to 4.9%	86,830	-	91,170													
Variable Baseline		**86,829**			$370,471.86	$370,471.86	$370,471.86	$370,471.86	$381,788.19	$381,788.19	$381,788.19	$381,788.19	$381,788.19	$381,788.19	$381,788.19	$381,788.19	$381,788.19
Deadband	-0% to -4.9%	86,828	-	82,487													
RRC 1	-5% to -9.9%	82,488	-	78,145	-$25,522.05	-$25,522.05	-$25,522.05	-$25,522.05	-$25,522.05	-$25,522.05	-$25,522.05	-$25,522.05	-$25,522.05	-$25,522.05	-$25,522.05	-$25,522.05	-$25,522.05
RRC 2	-10% to -14.9%	78,146	-	73,804	-$51,044.10	-$51,044.10	-$51,044.10	-$51,044.10	-$51,044.10	-$51,044.10	-$51,044.10	-$51,044.10	-$51,044.10	-$51,044.10	-$51,044.10	-$51,044.10	-$51,044.10
RRC 3	-15% to -19.9%	73,805	-	69,462	-$76,566.16	-$76,566.16	-$76,566.16	-$76,566.16	-$76,566.16	-$76,566.16	-$76,566.16	-$76,566.16	-$76,566.16	-$76,566.16	-$76,566.16	-$76,566.16	-$76,566.16
RRC 4	-20% to -24.9%	69,463	-	65,123	-$102,088.21	-$102,088.21	-$102,088.21	-$102,088.21	-$102,088.21	-$102,088.21	-$102,088.21	-$102,088.21	-$102,088.21	-$102,088.21	-$102,088.21	-$102,088.21	-$102,088.21
Reprice	-25%	< 65,122															
Variable Baseline FTE's					72.0	72.0	72.0	72.0	72.0	72.0	72.0	72.0	72.0	72.0	72.0	72.0	72.0

Provider Call ARC/RRC					Contract Year 2												
Effect	**% volume above the baseline***	**Volume**			**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	
Reprice	25%	> 108,536															
ARC 4	20% to 24.9%	104,195	-	108,535	$104,129.97	$104,129.97	$104,129.97	$104,129.97	$104,129.97	$104,129.97	$104,129.97	$104,129.97	$104,129.97	$104,129.97	$104,129.97	$104,129.97	
ARC 3	15% to 19.9%	99,854	-	104,194	$78,097.48	$78,097.48	$78,097.48	$78,097.48	$78,097.48	$78,097.48	$78,097.48	$78,097.48	$78,097.48	$78,097.48	$78,097.48	$78,097.48	
ARC 2	10% to 14.9%	95,512	-	99,853	$52,064.99	$52,064.99	$52,064.99	$52,064.99	$52,064.99	$52,064.99	$52,064.99	$52,064.99	$52,064.99	$52,064.99	$52,064.99	$52,064.99	
ARC 1	5% to 9.9%	91,171	-	95,511	$26,032.49	$26,032.49	$26,032.49	$26,032.49	$26,032.49	$26,032.49	$26,032.49	$26,032.49	$26,032.49	$26,032.49	$26,032.49	$26,032.49	
Deadband	0% to 4.9%	86,830	-	91,170													
Variable Baseline		**86,829**			$372,168.67	$372,168.67	$372,168.67	$383,343.93	$383,343.93	$383,343.93	$383,343.93	$383,343.93	$383,343.93	$383,343.93	$383,343.93	$383,343.93	
Deadband	-0% to -4.9%	86,828	-	82,487													
RRC 1	-5% to -9.9%	82,488	-	78,145	-$26,032.49	-$26,032.49	-$26,032.49	-$26,032.49	-$26,032.49	-$26,032.49	-$26,032.49	-$26,032.49	-$26,032.49	-$26,032.49	-$26,032.49	-$26,032.49	
RRC 2	-10% to -14.9%	78,146	-	73,804	-$52,064.99	-$52,064.99	-$52,064.99	-$52,064.99	-$52,064.99	-$52,064.99	-$52,064.99	-$52,064.99	-$52,064.99	-$52,064.99	-$52,064.99	-$52,064.99	
RRC 3	-15% to -19.9%	73,805	-	69,462	-$78,097.48	-$78,097.48	-$78,097.48	-$78,097.48	-$78,097.48	-$78,097.48	-$78,097.48	-$78,097.48	-$78,097.48	-$78,097.48	-$78,097.48	-$78,097.48	
RRC 4	-20% to -24.9%	69,463	-	65,123	-$104,129.97	-$104,129.97	-$104,129.97	-$104,129.97	-$104,129.97	-$104,129.97	-$104,129.97	-$104,129.97	-$104,129.97	-$104,129.97	-$104,129.97	-$104,129.97	
Reprice	-25%	< 65,122															
Variable Baseline FTE's					72.0	72.0	72.0	72.0	72.0	72.0	72.0	72.0	72.0	72.0	72.0	72.0	

Provider Call ARC/RRC					Contract Year 3												
Effect	**% volume above the baseline***	**Volume**			**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	
Reprice	25%	> 108,536															
ARC 4	20% to 24.9%	104,195	-	108,535	$81,879.98	$81,879.98	$81,879.98	$81,879.98	$81,879.98	$81,879.98	$81,879.98	$81,879.98	$81,879.98	$81,879.98	$81,879.98	$81,879.98	
ARC 3	15% to 19.9%	99,854	-	104,194	$61,409.98	$61,409.98	$61,409.98	$61,409.98	$61,409.98	$61,409.98	$61,409.98	$61,409.98	$61,409.98	$61,409.98	$61,409.98	$61,409.98	
ARC 2	10% to 14.9%	95,512	-	99,853	$40,939.99	$40,939.99	$40,939.99	$40,939.99	$40,939.99	$40,939.99	$40,939.99	$40,939.99	$40,939.99	$40,939.99	$40,939.99	$40,939.99	
ARC 1	5% to 9.9%	91,171	-	95,511	$20,469.99	$20,469.99	$20,469.99	$20,469.99	$20,469.99	$20,469.99	$20,469.99	$20,469.99	$20,469.99	$20,469.99	$20,469.99	$20,469.99	
Deadband	0% to 4.9%	86,830	-	91,170													
Variable Baseline		**86,829**			$221,182.72	$221,182.72	$221,182.72	$227,881.16	$227,881.16	$227,881.16	$227,881.16	$227,881.16	$227,881.16	$227,881.16	$227,881.16	$227,881.16	
Deadband	-0% to -4.9%	86,828	-	82,487													
RRC 1	-5% to -9.9%	82,488	-	78,145	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99	
RRC 2	-10% to -14.9%	78,146	-	73,804	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99	
RRC 3	-15% to -19.9%	73,805	-	69,462	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98	
RRC 4	-20% to -24.9%	69,463	-	65,123	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98	
Reprice	-25%	< 65,122															
Variable Baseline FTE's					51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	

Prior Authorization Calls ARCs/RRCs Table

Prior Authorization Calls ARC/RRC					Contract Year 1												
Effect	**% volume above the baseline***	**Volume**			**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**
Reprice	40%	> 20,300															
ARC 3	30% to 39.9%	18,850	-	20,299	$175,574.78	$175,574.78	$175,574.78	$175,574.78	$175,574.78	$175,574.78	$175,574.78	$175,574.78	$175,574.78	$175,574.78	$175,574.78	$175,574.78	$175,574.78
ARC 2	20% to 29.9%	17,400	-	18,849	$117,049.86	$117,049.86	$117,049.86	$117,049.86	$117,049.86	$117,049.86	$117,049.86	$117,049.86	$117,049.86	$117,049.86	$117,049.86	$117,049.86	$117,049.86
ARC 1	10% to 19.9%	15,950	-	17,399	$58,524.93	$58,524.93	$58,524.93	$58,524.93	$58,524.93	$58,524.93	$58,524.93	$58,524.93	$58,524.93	$58,524.93	$58,524.93	$58,524.93	$58,524.93
Deadband	0% to 9.9%	14,501	-	15,949													
Variable Baseline		**14,500**			$746,455.35	$746,455.35	$746,455.35	$746,455.35	$766,699.87	$766,699.87	$766,699.87	$766,699.87	$766,699.87	$766,699.87	$766,699.87	$766,699.87	$766,699.87
Deadband	-0% to -9.9%	14,499	-	13,049													
RRC 1	-10% to -19.9%	13,050	-	11,599	-$58,524.93	-$58,524.93	-$58,524.93	-$58,524.93	-$58,524.93	-$58,524.93	-$58,524.93	-$58,524.93	-$58,524.93	-$58,524.93	-$58,524.93	-$58,524.93	-$58,524.93
RRC 2	-20% to -29.9%	11,600	-	10,149	-$117,049.86	-$117,049.86	-$117,049.86	-$117,049.86	-$117,049.86	-$117,049.86	-$117,049.86	-$117,049.86	-$117,049.86	-$117,049.86	-$117,049.86	-$117,049.86	-$117,049.86
RRC 3	-30% to -39.9%	10,150	-	8,701	-$175,574.78	-$175,574.78	-$175,574.78	-$175,574.78	-$175,574.78	-$175,574.78	-$175,574.78	-$175,574.78	-$175,574.78	-$175,574.78	-$175,574.78	-$175,574.78	-$175,574.78
Reprice	-40%	< 8,700															
Variable Baseline FTE's					62.5	62.5	62.5	62.5	62.5	62.5	62.5	62.5	62.5	62.5	62.5	62.5	62.5

Prior Authorization Calls ARC/RRC					Contract Year 2												
Effect	**% volume above the baseline***	**Volume**			**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	
Reprice	40%	> 20,300															
ARC 3	30% to 39.9%	18,850	-	20,299	$179,086.28	$179,086.28	$179,086.28	$179,086.28	$179,086.28	$179,086.28	$179,086.28	$179,086.28	$179,086.28	$179,086.28	$179,086.28	$179,086.28	
ARC 2	20% to 29.9%	17,400	-	18,849	$119,390.85	$119,390.85	$119,390.85	$119,390.85	$119,390.85	$119,390.85	$119,390.85	$119,390.85	$119,390.85	$119,390.85	$119,390.85	$119,390.85	
ARC 1	10% to 19.9%	15,950	-	17,399	$59,695.43	$59,695.43	$59,695.43	$59,695.43	$59,695.43	$59,695.43	$59,695.43	$59,695.43	$59,695.43	$59,695.43	$59,695.43	$59,695.43	
Deadband	0% to 9.9%	14,501	-	15,949													
Variable Baseline		**14,500**			$743,182.70	$743,182.70	$743,182.70	$762,992.44	$762,992.44	$762,992.44	$762,992.44	$762,992.44	$762,992.44	$762,992.44	$762,992.44	$762,992.44	
Deadband	-0% to -9.9%	14,499	-	13,049													
RRC 1	-10% to -19.9%	13,050	-	11,599	-$59,695.43	-$59,695.43	-$59,695.43	-$59,695.43	-$59,695.43	-$59,695.43	-$59,695.43	-$59,695.43	-$59,695.43	-$59,695.43	-$59,695.43	-$59,695.43	
RRC 2	-20% to -29.9%	11,600	-	10,149	-$119,390.85	-$119,390.85	-$119,390.85	-$119,390.85	-$119,390.85	-$119,390.85	-$119,390.85	-$119,390.85	-$119,390.85	-$119,390.85	-$119,390.85	-$119,390.85	
RRC 3	-30% to -39.9%	10,150	-	8,701	-$179,086.28	-$179,086.28	-$179,086.28	-$179,086.28	-$179,086.28	-$179,086.28	-$179,086.28	-$179,086.28	-$179,086.28	-$179,086.28	-$179,086.28	-$179,086.28	
Reprice	-40%	< 8,700															
Variable Baseline FTE's					60.5	60.5	60.5	60.5	60.5	60.5	60.5	60.5	60.5	60.5	60.5	60.5	

Prior Authorization Calls ARC/RRC					Contract Year 3												
Effect	**% volume above the baseline***	**Volume**			**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	
Reprice	40%	> 20,300															
ARC 3	30% to 39.9%	18,850	-	20,299	$182,597.77	$182,597.77	$182,597.77	$182,597.77	$182,597.77	$182,597.77	$182,597.77	$182,597.77	$182,597.77	$182,597.77	$182,597.77	$182,597.77	
ARC 2	20% to 29.9%	17,400	-	18,849	$121,731.85	$121,731.85	$121,731.85	$121,731.85	$121,731.85	$121,731.85	$121,731.85	$121,731.85	$121,731.85	$121,731.85	$121,731.85	$121,731.85	
ARC 1	10% to 19.9%	15,950	-	17,399	$60,865.92	$60,865.92	$60,865.92	$60,865.92	$60,865.92	$60,865.92	$60,865.92	$60,865.92	$60,865.92	$60,865.92	$60,865.92	$60,865.92	
Deadband	0% to 9.9%	14,501	-	15,949													
Variable Baseline		**14,500**			$740,561.12	$740,561.12	$740,561.12	$760,300.10	$760,300.10	$760,300.10	$760,300.10	$760,300.10	$760,300.10	$760,300.10	$760,300.10	$760,300.10	
Deadband	-0% to -9.9%	14,499	-	13,049													
RRC 1	-10% to -19.9%	13,050	-	11,599	-$60,865.92	-$60,865.92	-$60,865.92	-$60,865.92	-$60,865.92	-$60,865.92	-$60,865.92	-$60,865.92	-$60,865.92	-$60,865.92	-$60,865.92	-$60,865.92	
RRC 2	-20% to -29.9%	11,600	-	10,149	-$121,731.85	-$121,731.85	-$121,731.85	-$121,731.85	-$121,731.85	-$121,731.85	-$121,731.85	-$121,731.85	-$121,731.85	-$121,731.85	-$121,731.85	-$121,731.85	
RRC 3	-30% to -39.9%	10,150	-	8,701	-$182,597.77	-$182,597.77	-$182,597.77	-$182,597.77	-$182,597.77	-$182,597.77	-$182,597.77	-$182,597.77	-$182,597.77	-$182,597.77	-$182,597.77	-$182,597.77	
Reprice	-40%	< 8,700															
Variable Baseline FTE's					58.5	58.5	58.5	58.5	58.5	58.5	58.5	58.5	58.5	58.5	58.5	58.5	

Client Calls ARCs/RRCs Table

Client Call ARC/RRC					Contract Year 1												
Effect	**% volume above the baseline***	**Volume**			**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**
Reprice	25%	> 98,531															
ARC 4	20% to 24.9%	94,590	-	98,530	$80,274.49	$80,274.49	$80,274.49	$80,274.49	$80,274.49	$80,274.49	$80,274.49	$80,274.49	$80,274.49	$80,274.49	$80,274.49	$80,274.49	$80,274.49
ARC 3	15% to 19.9%	90,649	-	94,589	$60,205.87	$60,205.87	$60,205.87	$60,205.87	$60,205.87	$60,205.87	$60,205.87	$60,205.87	$60,205.87	$60,205.87	$60,205.87	$60,205.87	$60,205.87
ARC 2	10% to 14.9%	86,708	-	90,648	$40,137.24	$40,137.24	$40,137.24	$40,137.24	$40,137.24	$40,137.24	$40,137.24	$40,137.24	$40,137.24	$40,137.24	$40,137.24	$40,137.24	$40,137.24
ARC 1	5% to 9.9%	82,766	-	86,707	$20,068.62	$20,068.62	$20,068.62	$20,068.62	$20,068.62	$20,068.62	$20,068.62	$20,068.62	$20,068.62	$20,068.62	$20,068.62	$20,068.62	$20,068.62
Deadband	0% to 4.9%	78,826	-	82,765													
Variable Baseline		**78,825**			$216,888.49	$216,888.49	$216,888.49	$216,888.49	$223,570.52	$223,570.52	$223,570.52	$223,570.52	$223,570.52	$223,570.52	$223,570.52	$223,570.52	$223,570.52
Deadband	-0% to -4.9%	78,824	-	74,883													
RRC 1	-5% to -9.9%	74,884	-	70,942	-$20,068.62	-$20,068.62	-$20,068.62	-$20,068.62	-$20,068.62	-$20,068.62	-$20,068.62	-$20,068.62	-$20,068.62	-$20,068.62	-$20,068.62	-$20,068.62	-$20,068.62
RRC 2	-10% to -14.9%	70,943	-	67,000	-$40,137.24	-$40,137.24	-$40,137.24	-$40,137.24	-$40,137.24	-$40,137.24	-$40,137.24	-$40,137.24	-$40,137.24	-$40,137.24	-$40,137.24	-$40,137.24	-$40,137.24
RRC 3	-15% to -19.9%	67,001	-	63,059	-$60,205.87	-$60,205.87	-$60,205.87	-$60,205.87	-$60,205.87	-$60,205.87	-$60,205.87	-$60,205.87	-$60,205.87	-$60,205.87	-$60,205.87	-$60,205.87	-$60,205.87
RRC 4	-20% to -24.9%	63,060	-	59,120	-$80,274.49	-$80,274.49	-$80,274.49	-$80,274.49	-$80,274.49	-$80,274.49	-$80,274.49	-$80,274.49	-$80,274.49	-$80,274.49	-$80,274.49	-$80,274.49	-$80,274.49
Reprice	-25%	< 59,119															
Variable Baseline FTE's					51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0

Client Call ARC/RRC					Contract Year 2											
Effect	**% volume above the baseline***	**Volume**			**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**
Reprice	25%	> 98,531														
ARC 4	20% to 24.9%	94,590	-	98,530	$81,879.98	$81,879.98	$81,879.98	$81,879.98	$81,879.98	$81,879.98	$81,879.98	$81,879.98	$81,879.98	$81,879.98	$81,879.98	$81,879.98
ARC 3	15% to 19.9%	90,649	-	94,589	$61,409.98	$61,409.98	$61,409.98	$61,409.98	$61,409.98	$61,409.98	$61,409.98	$61,409.98	$61,409.98	$61,409.98	$61,409.98	$61,409.98
ARC 2	10% to 14.9%	86,708	-	90,648	$40,939.99	$40,939.99	$40,939.99	$40,939.99	$40,939.99	$40,939.99	$40,939.99	$40,939.99	$40,939.99	$40,939.99	$40,939.99	$40,939.99
ARC 1	5% to 9.9%	82,766	-	86,707	$20,469.99	$20,469.99	$20,469.99	$20,469.99	$20,469.99	$20,469.99	$20,469.99	$20,469.99	$20,469.99	$20,469.99	$20,469.99	$20,469.99
Deadband	0% to 4.9%	78,826	-	82,765												
Variable Baseline		**78,825**			$221,182.72	$221,182.72	$221,182.72	$227,881.16	$227,881.16	$227,881.16	$227,881.16	$227,881.16	$227,881.16	$227,881.16	$227,881.16	$227,881.16
Deadband	-0% to -4.9%	78,824	-	74,883												
RRC 1	-5% to -9.9%	74,884	-	70,942	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99	-$20,469.99
RRC 2	-10% to -14.9%	70,943	-	67,000	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99	-$40,939.99
RRC 3	-15% to -19.9%	67,001	-	63,059	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98	-$61,409.98
RRC 4	-20% to -24.9%	63,060	-	59,120	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98	-$81,879.98
Reprice	-25%	< 59,119														
Variable Baseline FTE's					51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0

Client Call ARC/RRC					Contract Year 3											
Effect	**% volume above the baseline***	**Volume**			**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**
Reprice	25%	> 98,531														
ARC 4	20% to 24.9%	94,590	-	98,530	$83,485.47	$83,485.47	$83,485.47	$83,485.47	$83,485.47	$83,485.47	$83,485.47	$83,485.47	$83,485.47	$83,485.47	$83,485.47	$83,485.47
ARC 3	15% to 19.9%	90,649	-	94,589	$62,614.10	$62,614.10	$62,614.10	$62,614.10	$62,614.10	$62,614.10	$62,614.10	$62,614.10	$62,614.10	$62,614.10	$62,614.10	$62,614.10
ARC 2	10% to 14.9%	86,708	-	90,648	$41,742.73	$41,742.73	$41,742.73	$41,742.73	$41,742.73	$41,742.73	$41,742.73	$41,742.73	$41,742.73	$41,742.73	$41,742.73	$41,742.73
ARC 1	5% to 9.9%	82,766	-	86,707	$20,871.37	$20,871.37	$20,871.37	$20,871.37	$20,871.37	$20,871.37	$20,871.37	$20,871.37	$20,871.37	$20,871.37	$20,871.37	$20,871.37
Deadband	0% to 4.9%	78,826	-	82,765												
Variable Baseline		**78,825**			$225,421.05	$225,421.05	$225,421.05	$232,247.84	$232,247.84	$232,247.84	$232,247.84	$232,247.84	$232,247.84	$232,247.84	$232,247.84	$232,247.84
Deadband	-0% to -4.9%	78,824	-	74,883												
RRC 1	-5% to -9.9%	74,884	-	70,942	-$20,871.37	-$20,871.37	-$20,871.37	-$20,871.37	-$20,871.37	-$20,871.37	-$20,871.37	-$20,871.37	-$20,871.37	-$20,871.37	-$20,871.37	-$20,871.37
RRC 2	-10% to -14.9%	70,943	-	67,000	-$41,742.73	-$41,742.73	-$41,742.73	-$41,742.73	-$41,742.73	-$41,742.73	-$41,742.73	-$41,742.73	-$41,742.73	-$41,742.73	-$41,742.73	-$41,742.73
RRC 3	-15% to -19.9%	67,001	-	63,059	-$62,614.10	-$62,614.10	-$62,614.10	-$62,614.10	-$62,614.10	-$62,614.10	-$62,614.10	-$62,614.10	-$62,614.10	-$62,614.10	-$62,614.10	-$62,614.10
RRC 4	-20% to -24.9%	63,060	-	59,120	-$83,485.47	-$83,485.47	-$83,485.47	-$83,485.47	-$83,485.47	-$83,485.47	-$83,485.47	-$83,485.47	-$83,485.47	-$83,485.47	-$83,485.47	-$83,485.47
Reprice	-25%	< 59,119														
Variable Baseline FTE's					51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0	51.0

Long-Term Care Operations ARCs/RRCs Table

LTC ARC/RRC					Contract Year 1												
Effect	% volume above the baseline*	Volume			Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Reprice	40%	> 31,139															
ARC 3	30% to 39.9%	28,915	-	31,138	$40,763.35	$40,763.35	$40,763.35	$40,763.35	$40,763.35	$40,763.35	$40,763.35	$40,763.35	$40,763.35	$40,763.35	$40,763.35	$40,763.35	$40,763.35
ARC 2	20% to 29.9%	26,690	-	28,914	$27,175.56	$27,175.56	$27,175.56	$27,175.56	$27,175.56	$27,175.56	$27,175.56	$27,175.56	$27,175.56	$27,175.56	$27,175.56	$27,175.56	$27,175.56
ARC 1	10% to 19.9%	24,466	-	26,689	$13,587.78	$13,587.78	$13,587.78	$13,587.78	$13,587.78	$13,587.78	$13,587.78	$13,587.78	$13,587.78	$13,587.78	$13,587.78	$13,587.78	$13,587.78
Deadband	0% to 9.9%	22,243	-	24,465													
Variable Baseline		**22,242**			$161,893.59	$161,893.59	$161,893.59	$161,893.59	$166,689.63	$166,689.63	$166,689.63	$166,689.63	$166,689.63	$166,689.63	$166,689.63	$166,689.63	$166,689.63
Deadband	-0% to -9.9%	22,241	-	20,017													
RRC 1	-10% to -19.9%	20,018	-	17,793	-$13,587.78	-$13,587.78	-$13,587.78	-$13,587.78	-$13,587.78	-$13,587.78	-$13,587.78	-$13,587.78	-$13,587.78	-$13,587.78	-$13,587.78	-$13,587.78	-$13,587.78
RRC 2	-20% to -29.9%	17,794	-	15,568	-$27,175.56	-$27,175.56	-$27,175.56	-$27,175.56	-$27,175.56	-$27,175.56	-$27,175.56	-$27,175.56	-$27,175.56	-$27,175.56	-$27,175.56	-$27,175.56	-$27,175.56
RRC 3	-30% to -39.9%	15,569	-	13,346	-$40,763.35	-$40,763.35	-$40,763.35	-$40,763.35	-$40,763.35	-$40,763.35	-$40,763.35	-$40,763.35	-$40,763.35	-$40,763.35	-$40,763.35	-$40,763.35	-$40,763.35
Reprice	-40%	< 13,345															
Variable Baseline FTE's					12.0	12.0	12.0	12.0	12.0	12.0	12.0	12.0	12.0	12.0	12.0	12.0	12.0

LTC ARC/RRC					Contract Year 2												
Effect	% volume above the baseline*	Volume			Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	
Reprice	40%	> 31,139															
ARC 3	30% to 39.9%	28,915	-	31,138	$41,578.61	$41,578.61	$41,578.61	$41,578.61	$41,578.61	$41,578.61	$41,578.61	$41,578.61	$41,578.61	$41,578.61	$41,578.61	$41,578.61	
ARC 2	20% to 29.9%	26,690	-	28,914	$27,719.08	$27,719.08	$27,719.08	$27,719.08	$27,719.08	$27,719.08	$27,719.08	$27,719.08	$27,719.08	$27,719.08	$27,719.08	$27,719.08	
ARC 1	10% to 19.9%	24,466	-	26,689	$13,859.54	$13,859.54	$13,859.54	$13,859.54	$13,859.54	$13,859.54	$13,859.54	$13,859.54	$13,859.54	$13,859.54	$13,859.54	$13,859.54	
Deadband	0% to 9.9%	22,243	-	24,465													
Variable Baseline		**22,242**			$166,669.78	$166,669.78	$166,669.78	$171,529.50	$171,529.50	$171,529.50	$171,529.50	$171,529.50	$171,529.50	$171,529.50	$171,529.50	$171,529.50	
Deadband	-0% to -9.9%	22,241	-	20,017													
RRC 1	-10% to -19.9%	20,018	-	17,793	-$13,859.54	-$13,859.54	-$13,859.54	-$13,859.54	-$13,859.54	-$13,859.54	-$13,859.54	-$13,859.54	-$13,859.54	-$13,859.54	-$13,859.54	-$13,859.54	
RRC 2	-20% to -29.9%	17,794	-	15,568	-$27,719.08	-$27,719.08	-$27,719.08	-$27,719.08	-$27,719.08	-$27,719.08	-$27,719.08	-$27,719.08	-$27,719.08	-$27,719.08	-$27,719.08	-$27,719.08	
RRC 3	-30% to -39.9%	15,569	-	13,346	-$41,578.61	-$41,578.61	-$41,578.61	-$41,578.61	-$41,578.61	-$41,578.61	-$41,578.61	-$41,578.61	-$41,578.61	-$41,578.61	-$41,578.61	-$41,578.61	
Reprice	-40%	< 13,345															
Variable Baseline FTE's					12.0	12.0	12.0	12.0	12.0	12.0	12.0	12.0	12.0	12.0	12.0	12.0	

LTC ARC/RRC					Contract Year 3												
Effect	% volume above the baseline*	Volume			Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	
Reprice	40%	> 31,139															
ARC 3	30% to 39.9%	28,915	-	31,138	$42,393.88	$42,393.88	$42,393.88	$42,393.88	$42,393.88	$42,393.88	$42,393.88	$42,393.88	$42,393.88	$42,393.88	$42,393.88	$42,393.88	
ARC 2	20% to 29.9%	26,690	-	28,914	$28,262.59	$28,262.59	$28,262.59	$28,262.59	$28,262.59	$28,262.59	$28,262.59	$28,262.59	$28,262.59	$28,262.59	$28,262.59	$28,262.59	
ARC 1	10% to 19.9%	24,466	-	26,689	$14,131.29	$14,131.29	$14,131.29	$14,131.29	$14,131.29	$14,131.29	$14,131.29	$14,131.29	$14,131.29	$14,131.29	$14,131.29	$14,131.29	
Deadband	0% to 9.9%	22,243	-	24,465													
Variable Baseline		**22,242**			$171,509.65	$171,509.65	$171,509.65	$176,516.55	$176,516.55	$176,516.55	$176,516.55	$176,516.55	$176,516.55	$176,516.55	$176,516.55	$176,516.55	
Deadband	-0% to -9.9%	22,241	-	20,017													
RRC 1	-10% to -19.9%	20,018	-	17,793	-$14,131.29	-$14,131.29	-$14,131.29	-$14,131.29	-$14,131.29	-$14,131.29	-$14,131.29	-$14,131.29	-$14,131.29	-$14,131.29	-$14,131.29	-$14,131.29	
RRC 2	-20% to -29.9%	17,794	-	15,568	-$28,262.59	-$28,262.59	-$28,262.59	-$28,262.59	-$28,262.59	-$28,262.59	-$28,262.59	-$28,262.59	-$28,262.59	-$28,262.59	-$28,262.59	-$28,262.59	
RRC 3	-30% to -39.9%	15,569	-	13,346	-$42,393.88	-$42,393.88	-$42,393.88	-$42,393.88	-$42,393.88	-$42,393.88	-$42,393.88	-$42,393.88	-$42,393.88	-$42,393.88	-$42,393.88	-$42,393.88	
Reprice	-40%	< 13,345															
Variable Baseline FTE's					11.0	11.0	11.0	11.0	11.0	11.0	11.0	11.0	11.0	11.0	11.0	11.0	

Provider Enrollment ARCs/RRCs Table

Provider Enrollment ARC/RRC					Contract Year 1												
Effect	**% volume above the baseline***	**Volume**			**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**
Reprice	25%	> 20,000															
ARC 4	20% to 24.9%	19,200	-	19,999	$131,610.51	$131,610.51	$131,610.51	$131,610.51	$131,610.51	$131,610.51	$131,610.51	$131,610.51	$131,610.51	$131,610.51	$131,610.51	$131,610.51	$131,610.51
ARC 3	15% to 19.9%	18,400	-	19,199	$98,707.88	$98,707.88	$98,707.88	$98,707.88	$98,707.88	$98,707.88	$98,707.88	$98,707.88	$98,707.88	$98,707.88	$98,707.88	$98,707.88	$98,707.88
ARC 2	10% to 14.9%	17,600	-	18,399	$65,805.26	$65,805.26	$65,805.26	$65,805.26	$65,805.26	$65,805.26	$65,805.26	$65,805.26	$65,805.26	$65,805.26	$65,805.26	$65,805.26	$65,805.26
ARC 1	5% to 9.9%	16,800	-	17,599	$32,902.63	$32,902.63	$32,902.63	$32,902.63	$32,902.63	$32,902.63	$32,902.63	$32,902.63	$32,902.63	$32,902.63	$32,902.63	$32,902.63	$32,902.63
Deadband	0% to 4.9%	16,001	-	16,799													
Variable Baseline		**16,000**			$370,325.43	$370,554.94	$370,554.94	$370,554.94	$381,491.23	$381,491.23	$383,104.28	$383,104.28	$383,104.28	$383,104.28	$383,104.28	$383,104.28	$383,116.49
Deadband	-0% to -4.9%	15,999	-	15,199													
RRC 1	-5% to -9.9%	15,200	-	14,399	-$32,902.63	-$32,902.63	-$32,902.63	-$32,902.63	-$32,902.63	-$32,902.63	-$32,902.63	-$32,902.63	-$32,902.63	-$32,902.63	-$32,902.63	-$32,902.63	-$32,902.63
RRC 2	-10% to -14.9%	14,400	-	13,599	-$65,805.26	-$65,805.26	-$65,805.26	-$65,805.26	-$65,805.26	-$65,805.26	-$65,805.26	-$65,805.26	-$65,805.26	-$65,805.26	-$65,805.26	-$65,805.26	-$65,805.26
RRC 3	-15% to -19.9%	13,600	-	12,799	-$98,707.88	-$98,707.88	-$98,707.88	-$98,707.88	-$98,707.88	-$98,707.88	-$98,707.88	-$98,707.88	-$98,707.88	-$98,707.88	-$98,707.88	-$98,707.88	-$98,707.88
RRC 4	-20% to -24.9%	12,800	-	12,001	-$131,610.51	-$131,610.51	-$131,610.51	-$131,610.51	-$131,610.51	-$131,610.51	-$131,610.51	-$131,610.51	-$131,610.51	-$131,610.51	-$131,610.51	-$131,610.51	-$131,610.51
Reprice	-25%	< 12,000															
Variable Baseline FTE's					57.0	57.0	57.0	57.0	57.0	57.0	57.0	57.0	57.0	57.0	57.0	57.0	57.0

Provider Enrollment ARC/RRC					Contract Year 2												
Effect	**% volume above the baseline***	**Volume**			**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	
Reprice	25%	> 20,000															
ARC 4	20% to 24.9%	19,200	-	19,999	$134,242.72	$134,242.72	$134,242.72	$134,242.72	$134,242.72	$134,242.72	$134,242.72	$134,242.72	$134,242.72	$134,242.72	$134,242.72	$134,242.72	
ARC 3	15% to 19.9%	18,400	-	19,199	$100,682.04	$100,682.04	$100,682.04	$100,682.04	$100,682.04	$100,682.04	$100,682.04	$100,682.04	$100,682.04	$100,682.04	$100,682.04	$100,682.04	
ARC 2	10% to 14.9%	17,600	-	18,399	$67,121.36	$67,121.36	$67,121.36	$67,121.36	$67,121.36	$67,121.36	$67,121.36	$67,121.36	$67,121.36	$67,121.36	$67,121.36	$67,121.36	
ARC 1	5% to 9.9%	16,800	-	17,599	$33,560.68	$33,560.68	$33,560.68	$33,560.68	$33,560.68	$33,560.68	$33,560.68	$33,560.68	$33,560.68	$33,560.68	$33,560.68	$33,560.68	
Deadband	0% to 4.9%	16,001	-	16,799													
Variable Baseline		**16,000**			$379,733.74	$379,733.74	$379,733.74	$390,760.23	$390,760.23	$390,760.23	$390,760.23	$390,760.23	$390,760.23	$390,760.23	$390,760.23	$390,772.80	
Deadband	-0% to -4.9%	15,999	-	15,199													
RRC 1	-5% to -9.9%	15,200	-	14,399	-$33,560.68	-$33,560.68	-$33,560.68	-$33,560.68	-$33,560.68	-$33,560.68	-$33,560.68	-$33,560.68	-$33,560.68	-$33,560.68	-$33,560.68	-$33,560.68	
RRC 2	-10% to -14.9%	14,400	-	13,599	-$67,121.36	-$67,121.36	-$67,121.36	-$67,121.36	-$67,121.36	-$67,121.36	-$67,121.36	-$67,121.36	-$67,121.36	-$67,121.36	-$67,121.36	-$67,121.36	
RRC 3	-15% to -19.9%	13,600	-	12,799	-$100,682.04	-$100,682.04	-$100,682.04	-$100,682.04	-$100,682.04	-$100,682.04	-$100,682.04	-$100,682.04	-$100,682.04	-$100,682.04	-$100,682.04	-$100,682.04	
RRC 4	-20% to -24.9%	12,800	-	12,001	-$134,242.72	-$134,242.72	-$134,242.72	-$134,242.72	-$134,242.72	-$134,242.72	-$134,242.72	-$134,242.72	-$134,242.72	-$134,242.72	-$134,242.72	-$134,242.72	
Reprice	-25%	< 12,000															
Variable Baseline FTE's					55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	

Provider Enrollment ARC/RRC					Contract Year 3												
Effect	**% volume above the baseline***	**Volume**			**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	
Reprice	25%	> 20,000															
ARC 4	20% to 24.9%	19,200	-	19,999	$136,874.93	$136,874.93	$136,874.93	$136,874.93	$136,874.93	$136,874.93	$136,874.93	$136,874.93	$136,874.93	$136,874.93	$136,874.93	$136,874.93	
ARC 3	15% to 19.9%	18,400	-	19,199	$102,656.20	$102,656.20	$102,656.20	$102,656.20	$102,656.20	$102,656.20	$102,656.20	$102,656.20	$102,656.20	$102,656.20	$102,656.20	$102,656.20	
ARC 2	10% to 14.9%	17,600	-	18,399	$68,437.47	$68,437.47	$68,437.47	$68,437.47	$68,437.47	$68,437.47	$68,437.47	$68,437.47	$68,437.47	$68,437.47	$68,437.47	$68,437.47	
ARC 1	5% to 9.9%	16,800	-	17,599	$34,218.73	$34,218.73	$34,218.73	$34,218.73	$34,218.73	$34,218.73	$34,218.73	$34,218.73	$34,218.73	$34,218.73	$34,218.73	$34,218.73	
Deadband	0% to 4.9%	16,001	-	16,799													
Variable Baseline		**16,000**			$387,680.86	$387,680.86	$387,680.86	$398,946.32	$398,946.32	$398,946.32	$398,946.32	$398,946.32	$398,946.32	$398,946.32	$398,946.32	$398,959.27	
Deadband	-0% to -4.9%	15,999	-	15,199													
RRC 1	-5% to -9.9%	15,200	-	14,399	-$34,218.73	-$34,218.73	-$34,218.73	-$34,218.73	-$34,218.73	-$34,218.73	-$34,218.73	-$34,218.73	-$34,218.73	-$34,218.73	-$34,218.73	-$34,218.73	
RRC 2	-10% to -14.9%	14,400	-	13,599	-$68,437.47	-$68,437.47	-$68,437.47	-$68,437.47	-$68,437.47	-$68,437.47	-$68,437.47	-$68,437.47	-$68,437.47	-$68,437.47	-$68,437.47	-$68,437.47	
RRC 3	-15% to -19.9%	13,600	-	12,799	-$102,656.20	-$102,656.20	-$102,656.20	-$102,656.20	-$102,656.20	-$102,656.20	-$102,656.20	-$102,656.20	-$102,656.20	-$102,656.20	-$102,656.20	-$102,656.20	
RRC 4	-20% to -24.9%	12,800	-	12,001	-$136,874.93	-$136,874.93	-$136,874.93	-$136,874.93	-$136,874.93	-$136,874.93	-$136,874.93	-$136,874.93	-$136,874.93	-$136,874.93	-$136,874.93	-$136,874.93	
Reprice	-25%	< 12,000															
Variable Baseline FTE's					54.0	54.0	54.0	54.0	54.0	54.0	54.0	54.0	54.0	54.0	54.0	54.0	

CONTRACTOR Rates (Systems Maintenance, Modifications, and Additional Periodic Activities)			
Role	**Contract Year 1**	**Contract Year 2**	**Contract Year 3**
Medical Director	$ 223.69	$ 228.16	$ 232.73
Operations Director	$ 218.40	$ 222.77	$ 227.22
Clinical Operations Director	$ 206.00	$ 210.12	$ 214.32
Clinical Operations Management	$ 112.83	$ 115.09	$ 117.39
Operations Management	$ 103.38	$ 105.45	$ 107.56
Business Operations Analyst	$ 102.21	$ 104.25	$ 106.34
Registered Nurse (RN)	$ 86.35	$ 88.08	$ 89.84
Clinical Team Lead	$ 82.44	$ 84.09	$ 85.77
Licensed Therapist	$ 108.20	$ 110.36	$ 112.57
Licensed Vocation Nurse (LVN)	$ 71.27	$ 72.70	$ 74.15
Team Leader/ Supervisor	$ 72.61	$ 74.06	$ 75.54
Sr. Agent	$ 58.62	$ 59.79	$ 60.98
Health Management Specialist	$ 51.50	$ 52.53	$ 53.58
Health Management Jr. Specialist	$ 41.10	$ 41.92	$ 42.76
Agent	$ 47.40	$ 48.35	$ 49.32
Jr. Agent	$ 39.54	$ 40.33	$ 41.14
Program Manager	$ 255.78	$ 260.90	$ 266.12
Solution Architect	$ 171.66	$ 175.09	$ 178.59
Project Manager	$ 163.59	$ 166.87	$ 170.20
Sr Database Administrator - NSK	$ 162.00	$ 165.24	$ 168.55
Sr. Application Architect - C21	$ 151.15	$ 154.18	$ 157.26
Sr. Application Architect - V21	$ 150.24	$ 153.25	$ 156.31
Application Architect - C21	$ 146.27	$ 149.20	$ 152.18
Principal Consultant	$ 143.45	$ 146.32	$ 149.25
Sr. Database Administrator - Oracle	$ 143.38	$ 146.24	$ 149.17
Sr. Database Administrator - SQL	$ 143.38	$ 146.24	$ 149.17
Application Architect - V21	$ 142.38	$ 145.23	$ 148.13
Team Leader	$ 141.97	$ 144.81	$ 147.71
Sr. Application Architect -Portal	$ 138.54	$ 141.31	$ 144.13
Sr Devleloper- C21	$ 132.51	$ 135.16	$ 137.87
Sr Devleloper- V21	$ 131.67	$ 134.30	$ 136.99
Sr Devleloper- Portal	$ 128.59	$ 131.17	$ 133.79
Senior Consultant	$ 127.05	$ 129.59	$ 132.18
Application Architect - Portal	$ 126.88	$ 129.41	$ 132.00
System Programer	$ 126.88	$ 129.41	$ 132.00
Developer - C21	$ 115.60	$ 117.92	$ 120.27
Developer -V21	$ 115.60	$ 117.92	$ 120.27
Database Admininstrator	$ 115.48	$ 117.79	$ 120.14
Developer - Portal	$ 115.42	$ 117.73	$ 120.08
Sr. Business Analyst - C21	$ 114.04	$ 116.32	$ 118.64
Sr. Business Analyst - V21	$ 114.04	$ 116.32	$ 118.64
Sr. Business Analyst - Portal	$ 114.04	$ 116.32	$ 118.64
PMO Senior	$ 112.62	$ 114.87	$ 117.17
Sr. Programmer Analyst	$ 102.99	$ 105.05	$ 107.15
Programer Analyst	$ 102.17	$ 104.21	$ 106.29
Programmer	$ 97.16	$ 99.11	$ 101.09
Business Analyst - C21	$ 88.01	$ 89.77	$ 91.56
Business Analyst - V21	$ 88.01	$ 89.77	$ 91.56
Business Analyst - Portal	$ 88.01	$ 89.77	$ 91.56
PMO Junior	$ 85.36	$ 87.06	$ 88.80
Telephony Analyst	$ 81.14	$ 82.76	$ 84.42
Database Performance Analyst	$ 66.67	$ 68.00	$ 69.36
Quality Assurance Senior - Opns	$ 55.22	$ 56.32	$ 57.45
Quality Assurance Mid-Level - Opns	$ 46.81	$ 47.75	$ 48.70
Administrative Assistant	$ 43.21	$ 44.08	$ 44.96

These CONTRACTOR Rates will be utilized to calculate the Fees associated with all Change Order Requests relating to Systems Maintenance, Modifications, and Additional Periodic Activities.

Variable Unit Rate Fees

Category of Service	Unit Rates Operational Contract Year 1	Unit Rates Operational Contract Year 2	Unit Rates Operational Contract Year 3
SourceHOV			
Front-End Conversion			
Onsite Mailroom - Intake (Paper)	$ 0.12	$ 0.12	$ 0.12
Onsite Mailroom - Intake (Electronic)	$ 0.05	$ 0.05	$ 0.05
X-ray Intake	$ 1.00	$ 1.00	$ 1.00
Data Capture			
CMS1500 Single	$ 1.31	$ 1.31	$ 1.31
CMS1500 Multi	$ 1.46	$ 1.46	$ 1.46
CMS1500 Crossover	$ 1.75	$ 1.75	$ 1.75
CMS Advantage	$ 1.41	$ 1.41	$ 1.41
UB04 Single	$ 3.28	$ 3.28	$ 3.28
UB04 Multi	$ 3.75	$ 3.75	$ 3.75
UB04 Crossovers	$ 3.31	$ 3.31	$ 3.31
UB04 Advantage	$ 3.44	$ 3.44	$ 3.44
Dental Single	$ 2.17	$ 2.17	$ 2.17
Dental Multi	$ 3.61	$ 3.61	$ 3.61
Family Planning	$ 3.27	$ 3.27	$ 3.27
Correspondence Single / Multi	$ 2.50	$ 2.50	$ 2.50
Claim Adjustments	$ 1.31	$ 1.31	$ 1.31
RTP Single	$ 0.32	$ 0.32	$ 0.32
RTP Multi	$ 0.51	$ 0.51	$ 0.51
TPL Single	$ 0.33	$ 0.33	$ 0.33
TPL Multi	$ 0.49	$ 0.49	$ 0.49
Bad Address Indexing	$ 2.46	$ 2.46	$ 2.46
SUR Documentation	$ 0.91	$ 0.91	$ 0.91
Check Processing			
Check Indexing/Email	$ 1.92	$ 1.92	$ 1.92
Check scanning into JPMC via website	$ 0.15	$ 0.15	$ 0.15
Unacceptable Payee Check Return	$ 0.97	$ 0.97	$ 0.97
Foreign Language Call Handling (Language Select)			
Spanish translated calls handled	$ 1.37	$ 1.37	$ 1.37
Non-Spanish/non-English translated calls handled	$ 1.52	$ 1.52	$ 1.52
Radiology Prior Authorizations (eviCore)			
PA procedure codes dispositioned	$ 27.67	$ 27.67	$ 27.67
Letter Translation Services (Albornoz & Associates)			
Translated Medicaid Service Denial Letters from English to Spanish	$ 16.91	$ 16.91	$ 16.91

Contract Year 1 : August 1, 2017 – August 31, 2018 (13 Months)
Contract Year 2 : September 1, 2018 – August 31, 2019 (12 Months)
Contract Year 3 : September 1, 2019 – August 31, 2020 (12 Months)

Fixed Fees for Amendments from the Predecessor Contract (#529-14-0125-00003)

Month	Contract Period	16-025Rate Analysis Reporting Enhancements	16-027Provider Enrollment Enhancements	16-028CAPPS-SCOR Contract ID System Changes	16-029Medicare HICN Transition to MBI	HW/SW - 16-025Rate Analysis Reporting Enhancements	HW/SW - 16-027Provider Enrollment Enhancements	Total
August 2017	Contract Year 1	$ 253,798.30	$ 411,402.98	$ 169,187.28	$ 318,216.02	$ -	$ 1,376.94	$ 1,153,981.51
September 2017	Contract Year 1	$ 37,989.21	$ 418,140.29	$ 93,797.33	$ 321,029.32	$ 110.00	$ 1,376.94	$ 872,443.10
October 2017	Contract Year 1	$ 20,289.11	$ 408,427.24	$ -	$ 321,029.32	$ 43.00	$ -	$ 749,788.67
November 2017	Contract Year 1	$ 20,289.11	$ 413,719.29	$ -	$ 321,029.32	$ 35.00	$ 3,953.00	$ 759,025.72
December 2017	Contract Year 1	$ 20,289.11	$ 416,695.03	$ -	$ 284,348.45	$ -	$ -	$ 721,332.58
January 2018	Contract Year 1	$ 20,289.11	$ 226,033.13	$ -	$ 231,840.82	$ -	$ -	$ 478,163.06
February 2018	Contract Year 1	$ 20,289.11	$ 5,292.05	$ -	$ 84,153.23	$ -	$ 31,826.00	$ 141,560.39
March 2018	Contract Year 1	$ 20,289.11	$ 5,292.05	$ -	$ 75,356.63	$ -	$ -	$ 100,937.79
April 2018	Contract Year 1	$ 20,289.11	$ 5,292.05	$ -	$ 75,356.63	$ -	$ -	$ 100,937.79
May 2018	Contract Year 1	$ 20,289.11	$ 5,292.05	$ -	$ 75,356.63	$ -	$ -	$ 100,937.79
June 2018	Contract Year 1	$ -	$ 5,292.05	$ -	$ -	$ -	$ -	$ 5,292.05
July 2018	Contract Year 1	$ -	$ 5,292.05	$ -	$ -	$ -	$ -	$ 5,292.05
August 2018	Contract Year 1	$ -	$ 5,367.89	$ -	$ -	$ -	$ -	$ 5,367.89
Total Contract Year 1		**$ 454,100.38**	**$ 2,331,538.15**	**$ 262,984.61**	**$ 2,107,716.37**	**$ 188.00**	**$ 38,532.88**	**$ 5,195,060.39**

Contract Year 1 : August 1, 2017 – August 31, 2018 (13 Months)

Month	Contract Period	16-025Rate Analysis Reporting Enhancements	16-027Provider Enrollment Enhancements	16-028CAPPS-SCOR Contract ID System Changes	16-029Medicare HICN Transition to MBI	HW/SW - 16-025Rate Analysis Reporting Enhancements	HW/SW - 16-027Provider Enrollment Enhancements	Total
September 2018	Contract Year 2	$ -	$ 5,367.89	$ -	$ -	$ 67.00	$ -	$ 5,434.89
October 2018	Contract Year 2	$ -	$ 5,367.89	$ -	$ -	$ -	$ -	$ 5,367.89
November 2018	Contract Year 2	$ -	$ -	$ -	$ -	$ 35.00	$ -	$ 35.00
December 2018	Contract Year 2	$ -	$ -	$ -	$ -	$ -	$ -	$ -
January 2019	Contract Year 2	$ -	$ -	$ -	$ -	$ -	$ -	$ -
February 2019	Contract Year 2	$ -	$ -	$ -	$ -	$ -	$ 31,826.00	$ 31,826.00
March 2019	Contract Year 2	$ -	$ -	$ -	$ -	$ -	$ -	$ -
April 2019	Contract Year 2	$ -	$ -	$ -	$ -	$ -	$ -	$ -
May 2019	Contract Year 2	$ -	$ -	$ -	$ -	$ -	$ -	$ -
June 2019	Contract Year 2	$ -	$ -	$ -	$ -	$ -	$ -	$ -
July 2019	Contract Year 2	$ -	$ -	$ -	$ -	$ -	$ -	$ -
August 2019	Contract Year 2	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Contract Year 2		**$ -**	**$ 10,735.78**	**$ -**	**$ -**	**$ 102.00**	**$ 31,826.00**	**$ 42,663.78**

Contract Year 2 : September 1, 2018 – August 31, 2019 (12 Months)

	16-025Rate Analysis Reporting Enhancements	16-027Provider Enrollment Enhancements	16-028CAPPS-SCOR Contract ID System Changes	16-029Medicare HICN Transition to MBI	HW/SW - 16-025Rate Analysis Reporting Enhancements	HW/SW - 16-027Provider Enrollment Enhancements	TOTAL
Grand-Total Variable Fees (Contract Years 1, 2, 3)	**$ 454,100.38**	**$ 2,342,273.94**	**$ 262,984.61**	**$ 2,107,716.37**	**$ 290.00**	**$ 70,358.88**	**$ 5,237,724.17**

Contract Year s 1 - 3 : August 1, 2017 – August 31, 2020 (37 Months)

Note:
All Amendments from the predecessor contract are completed by the end of Contract Year 2. Therefore, Contract Year 3 is omitted from this schedule.

Contingency Fees (Percentages) for Third-Party Resources Services (TPR)	
TPR Functions	**Contingency Percentage**
TARS Billing	11.50%
Pharmacy Recovery	11.50%
Medicare Part D	11.50%
Credit Balance Audits	14.00%
TARS Encounter Billing	11.50%

TPR Functions	Monthly Expected Recoveries	Contingency Percentage
TORT Billing	Up to $1,000,000	9.00%
	Amount above $1,000,000 and up to $1,500,000	7.00%
	Amount above $1,500,000	6.00%

Contingency Fee Approach for TORT Billing

TORT Billings will follow a tiered approach, based on the volume of recoveries achieved. The tiers are as follows:

The first $1,000,000 of TORT Billing recoveries in a single month will result in a Contingency Fee of 9.0% of that recovery amount
The next $500,000 of TORT Billing recoveries in the same month will result in a Contingency Fee of 7.0% of this secondary amount
All TORT Billing recoveries over $1,500,000 in the same month will result in a Contingency Fee of 6.0% of the recoveries greater than $1,500,000

Example:

If we suppose that $2,150,000 of TORT Billing recoveries are made in a month, then the following Contingency Fees will apply and be billed:

$1,000,000 x 9% =	$90,000
$500,000 x 7% =	$35,000
$650,000 x 6% =	$39,000
$2,150,000	**$164,000**

Note: This demonstrates that each tier is standalone (i.e., the first $1,000,000 of recoveries will be at 9%, regardless of the total recoveries achieved)

The tiered approach for TORT Billing starts over for each month

EXHIBIT E

ACCENTURE PLC PERFORMANCE GUARANTEE

PREAMBLE:

This performance guarantee is dated May 15, 2017 ("**Guarantee**") and is made by:

(a) **ACCENTURE plc,** a company organised and existing under the laws of Ireland (the "**Guarantor**") with a registered office at 1 Grand Canal Square, Grand Canal Harbour, Dublin 2, Ireland; in favor of

(b) **The State of Texas Health and Human Services Commission** (the "**Guaranteed Party**") under the Agreement between the Guaranteed Party and the Subsidiary, designated as Contract No. 529-16-0007 (the "**Agreement**").

RECITALS:

(a) Accenture State Healthcare Services LLC, a company organized and existing under the laws of Delaware, is a subsidiary of the Guarantor (the "**Subsidiary**").

(b) The Guarantor is providing this guarantee to induce the Guaranteed Party to enter into the Agreement.

(c) The Guarantor provides the Guarantee on the following terms and conditions.

1. Defined Terms

Capitalized terms not otherwise defined in this Guarantee will have the same meanings given to them in the Agreement. The following terms will have the following meanings when used in this Guarantee:

"**Document**" means any document, instrument or other contract delivered, or given, in connection with the Agreement.

"**Guarantor**" means Accenture plc, defined in the preamble, together with its successors and assigns (whether by way of merger, sale of capital stock, sale of assets or otherwise).

"**Obligation**" means, with regard to the Agreement, the obligations and liabilities of the Subsidiary.

"**Other Taxes**" means any present or future stamp or documentary fees or taxes that arise from any payment made under this Guarantee, or from the execution, delivery or registration of this Guarantee (but excluding Taxes).

"**Person**" means an individual, partnership, corporation, joint venture, governmental authority or other entity of whatever nature.

"**Taxes**" means taxes imposed on the Guaranteed Party's net income (or franchise taxes imposed on the Guaranteed Party by the jurisdiction under the laws of which

it is organized or any political subdivision) and including any withholding made with respect to Taxes.

2. Guarantee

(a) The Guarantor absolutely, unconditionally and irrevocably guarantees to the Guaranteed Party the prompt and complete performance by the Subsidiary of the Obligations owed to the Guaranteed Party.

(b) In addition, the Guarantor will pay all reasonable expenses paid or incurred by the Guaranteed Party in enforcing any of its rights under this Guarantee.

(c) (i) Notwithstanding anything in this Guarantee (or in any Document), the maximum liability of the Guarantor in respect of any, or all, Obligations will in no event exceed **the liability set forth in Section 13.05 of the Agreement**.

(ii) Neither will the amount that can be guaranteed by the Guarantor exceed this maximum amount, as may be permissible under applicable law.

(iii) Except for variations in the limitation of liability set forth in Section 13.05 of the Agreement resulting from Amendments to the Statement of Work, the amount of the Guarantor's maximum liability under this Guarantee shall not be increased without the written approval of the Guarantor in accordance with Section 6(b).

(d) With the exception of enforcement costs described in Section 2(b), the Guarantor's liability with respect to this Guarantee will be co-extensive with, and limited to, that of the Subsidiary as provided in the Agreement.

3. Subsidiary Default

(a) Nothing in this Guarantee will grant to the Guaranteed Party any right of action against the Guarantor, unless:

(i) the Guaranteed Party has given all requisite notices of default or termination to the Subsidiary pursuant to the Agreement; and

(ii) all applicable cure periods, if any, for the Subsidiary to cure such default(s) have expired.

(b) The Guaranteed Party must:

(i) send to the Guarantor copies of any notice of default sent to the Subsidiary; and

(ii) must permit the Guarantor to cure the Subsidiary's default within the cure periods provided to the Subsidiary under the Agreement. For the avoidance of doubt, the cure period described in this section is not an additional cure period to the cure period afforded to Subsidiary under the Agreement

4. No Recourse

(a) No claim or recourse may be made, or will be had, under this Guarantee against any direct or indirect, past, present or future:

(i) partners;

(ii) members;

(iii) shareholders; or

(iv) holders of ownership interests

in the Guarantor, whether by statute, common law, by assessment, penalty or otherwise.

(b) The Guaranteed Party expressly and irrevocably waives, by virtue of its acceptance of or reliance upon this Guarantee or its benefits, any claim or recourse as set out in clause 4(a), and any liability otherwise arising from any such claim or recourse.

5. No Subrogation; Contribution

(a) The Guarantor will not be entitled to be subrogated to any of the rights of the Guaranteed Party, against the Subsidiary, for payment made by the Guarantor under this Guarantee.

(b) The Guarantor will not be entitled to seek any contribution from the Subsidiary for payments made by the Guarantor under this Guarantee - unless all amounts then due and payable to the Guaranteed Party under the Agreement (which have been demanded under this Guarantee) have been paid in full.

6. Amendments, etc. with respect to Obligations; Waiver of Rights

The obligations of the Guarantor under this Guarantee will remain in effect and will not be diminished or impaired, notwithstanding:

(a) any withdrawal of any demand by the Guaranteed Party, for payment or performance by the Subsidiary, of: (i) any Obligations; or (ii) for payment under this Guarantee;

(b) any amendment, extension, modification or waiver of any Obligations or of any Documents relating to them - provided that this Guarantee will only extend to any such amendment that increases the aggregate maximum guaranteed amount set out in Section 2(c) with the written approval of the Guarantor;

(c) any compromise by the Guaranteed Party of any Obligations and any other guarantee in respect of them;

(d) any invalidity or unenforceability of the Agreement (in whole or in part) against the Subsidiary (except that this provision shall not be a waiver of any Subsidiary claims under the Agreement); or

(e) any insolvency, bankruptcy, liquidation or dissolution of the Subsidiary.

7. Guarantee Continuing

(a) Except as otherwise provided in this Guarantee, the Guarantor waives any notice, of any kind, regarding the Obligations. This Guarantee will be construed as a continuing guarantee of performance of all Obligations owing to the Guaranteed Party by the Subsidiary under the Agreement.

(b) Except as described in Section 3 above, when pursuing its rights and remedies under this Guarantee against the Guarantor, the Guaranteed Party may, but will be under no obligation to, pursue such rights and remedies as it may have against the Subsidiary, until all the Obligations owing to the Guaranteed Party have been paid in full. Any failure by the Guaranteed Party to pursue any rights or remedies will not relieve the Guarantor from its obligations under this Guarantee.

(c) This Guarantee:

(i) remains in full force and effect;

(ii) is binding upon the Guarantor or its successors or and its respective successors or assigns;

until all the Obligations owed to the Guaranteed Party, and the obligations of the Guarantor under this Guarantee, have been satisfied in full.

8. Reinstatement

This Guarantee will be reinstated if any payment of an Obligation must be returned by the Guaranteed Party on the insolvency, bankruptcy, administration, dissolution or liquidation of the Subsidiary or the Guarantor.

9. Payments

Obligations owing to the Guaranteed Party will be paid in the currency and at the location specified in the Agreement and any related Documents.

10. Representations and Warranties

The Guarantor represents and warrants that:

(a) it is duly organized and validly existing under the laws of its jurisdiction of organization and has the power, authority and legal right to conduct its current business;

(b) it has the power, authority and the legal right to execute, and perform its obligations under, this Guarantee;

(c) this Guarantee constitutes a legal, valid and binding obligation on the Guarantor, enforceable in accordance with its terms but subject to:

(i) relevant laws affecting creditors' rights;

(ii) general equitable and common law principles; and

(iii) an implied covenant of good faith;

(d) the execution, delivery and performance of this Guarantee will not:

(i) contravene any applicable law, rule or regulation;

(ii) contravene any judgment, order, decree, agreement or undertaking applicable to the Guarantor; or

(iii) result in, or require, the imposition or creation of any lien on any the Guarantor's assets in any material respect;

(e) there are no laws in effect in the jurisdiction where the Guarantor is organized that limit its maximum liability - except for laws limiting the ability of the Guarantor to incur liabilities that render it either insolvent, unable to pay its debts or with insufficient capital; and

(f) it is not entitled to immunity from judicial proceedings and agrees that, in the event the Guaranteed Party brings a suit, action or proceeding in [ ] to enforce an obligation or liability of the Guarantor relating to this Guarantee, no immunity from such suit, action or proceeding will be claimed by, or on behalf of, the Guarantor.

11. Notices

(a) To be effective, all notices and demands on the Guaranteed Party or the Guarantor must be in writing (or by telex, fax or similar transmission) and will be deemed to have been duly given or made:

(i) if delivered by hand or courier, when delivered; or

(ii) if given by mail, five calendar days after the date when deposited in the mails by certified or registered mail; or

(iii) if by telex, fax or similar transmission, when sent and receipt has been confirmed, addressed as follows:

(A) if to the Guaranteed Party, at its address/number for notices provided in the Agreement, or if no such address/number is specified, then at the Guaranteed Party's main office; and

(B) if to the Guarantor, at its address/number for notices set forth under its signature below.

(b) The Guaranteed Party and the Guarantor may change their address/number for notices and demands by giving notice as provided in this Section 11.

12. Amendments in Writing; No Waiver; Cumulative Remedies

(a) Except as described in Section 6(b), no provision of this Guarantee may be waived, amended, supplemented or otherwise modified - except by written instrument signed by the Guarantor and Guaranteed Party.

(b) The Guaranteed Party will not, by any act (except by a written instrument pursuant to Section 12(a)) or by any delay or omission be deemed to have waived (in whole or in part) any right or remedy under this Guarantee.

(c) No failure to exercise, or any delay in exercising, by the Guaranteed Party of any right, power or privilege will operate as a waiver.

(d) A waiver by the Guaranteed Party of any right or remedy will not be construed as a bar to any right or remedy that the Guaranteed Party would otherwise have on any future occasion.

13. Judgment

The obligations of the Guarantor under this Guarantee for any amounts due to the Guaranteed Party will, notwithstanding any judgment in a currency (the "**judgment currency**") other than the currency in which such amount is denominated (the "**original currency**"), be discharged only to the extent that on the second business day following receipt by the Guaranteed Party of any sum in the judgment currency, the Guaranteed Party may, in accordance with normal banking procedures, purchase the original currency with the judgment currency; provided that if the amount of the original currency so purchased is less than the amount originally due to the Guaranteed Party in the original currency, the Guarantor agrees, as a separate obligation and notwithstanding any such judgment, to pay to the Guaranteed Party the amount of such loss within 90 days after demand.

14. Submission To Jurisdiction; Waivers

(a) The Guarantor irrevocably and unconditionally:

(i) submits itself to the non-exclusive general jurisdiction of the courts of the United States of America for the Southern District of New York and the Supreme Court of the State of New York located in the County and City of New York;

(ii) consents that any such action or proceeding may be brought in such courts and waives any objection it have to the venue;

(iii) agrees that service of process in any such action or proceeding may be effected by mailing a copy by registered or certified mail (or any substantially similar form of mail), postage prepaid, to the Guarantor as provided in Section 11;

(iv) agrees that nothing in this Section will affect the right of the Guaranteed Party to effect service of process in any other manner permitted by law; and

(v) appoints Jon Andrews (the "**Process Agent**") with an office as set forth in the Agreement, as its agent to receive on its behalf and its property service of copies of the summons and complaint and any other process which may be served in any action or proceeding in any court described in Section 14(a)(i) and agrees promptly to appoint a successor Process Agent (which successor Process Agent shall accept such appointment in a writing) prior to the termination for any reason of the appointment of the initial Process Agent or if the appointed Process Agent no longer maintains residence in Texas in a manner sufficient to act as Process Agent pursuant to applicable law. Guarantor will promptly notify the Guaranteed Party of any change to the Process Agent,

(b) In any action or proceeding in the State of New York, service may be made on the Guarantor by delivering a copy of the summons and complaint (and any other process) to the Guarantor in care of the Process Agent at the Process Agent's address and by depositing a copy of the process by certified or registered mail (addressed to the Guarantor as described in Section 11). The Guarantor irrevocably and unconditionally authorizes and directs the Process Agent to accept service on its behalf. The Guarantor agrees that, to the extent permitted by applicable law, a final judgment in any such action or proceeding will be conclusive and may be enforced in other jurisdictions.

(c) No further instrument or action, other than service of process as described above, will be necessary to confer jurisdiction upon the Guarantor in any court.

(d) Provided that service of process is effected upon the Guarantor as prescribed by law, the Guarantor irrevocably waives, to the fullest extent permitted by law, and agrees not to assert:

(i) any objection that it may have to the venue of any such suit, action or proceeding brought in a court in the State of New York;

(ii) any claim that any such suit, action or proceeding brought in a court in the State of New York has been brought in an inconvenient forum; or

(iii) any claim that is not personally subject to the jurisdiction of the courts of the United States of America for the Southern District of New York and the Supreme Court of the State of New York located in the County and City of New York.

15. Taxes

(a) All payments made by the Guarantor under this Guarantee will be free of, and without deduction for - all present or future fees, levies, imposts, deductions, charges or withholdings, and all liabilities - but excluding any Taxes. If the Guarantor is required by law to deduct Taxes from a sum payable under this Guarantee, the Guarantor will not reimburse the Guaranteed Party therefore, and will: (a) make such deductions; and (b) pay the full amount deducted to the relevant taxation authority in accordance with applicable law; and within 30 days of payment of Taxes, the Guarantor will furnish to the Guaranteed Party the original, or a certified copy, of a receipt evidencing payment.

(b) Within 30 days of the Guaranteed Party's request, the Guarantor will indemnify the Guaranteed Party for any Other Taxes paid by it, or any liability arising or with respect to such Other Taxes (whether or not such Other Taxes were correctly or legally asserted). The obligations contained in this paragraph will survive the payment in full of the Obligations and the termination or revocation of this Guarantee.

16. Waivers of Jury Trial

The Guarantor irrevocably and unconditionally waives trial by jury in any legal proceeding or counterclaim related to this Guarantee.

17. Successors and Assigns; Representatives

(a) This Guarantee will be binding upon the Guarantor and its successors and assigns, and will inure to the benefit of the Guaranteed Party (and its successors and assigns).

(b) In giving any notices or asserting any rights under this Guarantee, the Guaranteed Party may be represented by any trustee, agent or other similar representative. In such case, each reference to the Guaranteed Party will, as appropriate, be a reference to such trustee, agent or other representative.

(c) The Guarantor may:

(i) merge with another entity;

(ii) enter into a scheme of arrangement, amalgamation, consolidation or other combination; or

(iii) directly or indirectly, through its subsidiaries, sell or transfer all or substantially all of its assets or those of its subsidiaries to another entity or entities;

and, in connection with such transaction/s, assign all its rights and obligations under this Guarantee to the Guarantor's successor entity ("**Successor**").

(d) By accepting or relying on this Guarantee, the Guaranteed Party:

(i) consents to such transactions under Section 17(c), provided the Guarantor confirms that, upon completion of such transactions, the Successor will own and control total consolidated assets substantially equal to, or greater than, those owned and controlled by the Guarantor as of the Effective Date and that the Successor delivers to the Guaranteed Party a guarantee with terms conforming in all material aspects to this Guarantee; and

(ii) undertakes that it will enter into any instruments necessary or helpful to effect such transactions and transfers of the obligations hereunder between the Guarantor and Successor.

18. Governing Law

This Guarantee will be governed by, and construed and interpreted in accordance with, the laws of the State of Texas.

19. Partial Invalidity

If any provision of this Guarantee is held invalid, unenforceable or illegal for any reason, this Guarantee will remain otherwise in full force apart from such provision which will be deemed deleted.

20. Consideration

(a) It is a condition of the execution of the Agreement that the Guarantor execute this Guarantee.

(b) The Guarantor acknowledges and agrees that the execution of the Agreement by the Subsidiary is in the Guarantor's best interests.

(c) The Guarantor makes this Guarantee knowing that the Guaranteed Party will rely on this Guarantee in entering into the Agreement.

ACCENTURE PLC

Name: Scott K. Ahlstrom

Title: Treasurer

Address for Notices:

Accenture plc,
161 North Clark St.
Chicago, Illinois 60601-3200
U.S.A
Facsimile No. (312) 652-1584
(or, if different, the then current principal business address of the duly appointed General Counsel of Accenture plc)

ANNEXURE A
To Guarantee

Agreement

EXHIBIT F

Required Certifications

Instructions: This form must be submitted as an attachment to the respondent's proposal, and must be signed in ink by an individual who is authorized to bind the respondent.

By submitting a proposal, the respondent agrees and certifies the following.

1. The respondent accepts the RFP terms and conditions, including HHSC's Uniform Contract Terms and Conditions, and other RFP requirements unless specifically noted on the Respondent Information and Disclosure Form. HHSC reserves the right to reject any or all of the respondent's proposed exceptions.

2. The respondent's proposal will remain a firm and binding offer for 240 days from the date the proposal is due.

3. The respondent guarantees that the proposal complies with all RFP requirements, at the costs outlined in the proposal. The respondent further guarantees that the terms specified in the proposal will remain firm and binding through the contract termination date, unless the parties agree to modify such terms in the contract.

4. HHSC will have the right to use, produce and distribute copies of, and disclose all or part of the proposal to HHSC's employees, agents, and contractors and other governmental entities as HHSC deems necessary to complete the procurement process or comply with state or federal laws.

5. Neither the respondent nor any firm, corporation, partnership, or institution represented by the respondent, nor anyone acting for such firm, corporation, partnership or institution has: (1) violated the antitrust laws of the State of Texas under TEX. BUS. & COM. CODE, Chapter 15, or federal antitrust laws, or (2) communicated directly or indirectly the proposal to any competitor or any other person engaged in such line of business during the procurement process.

6. All prices proposed by the respondent have been arrived at independently. The respondent has not, for the purpose of restricting competition, consulted, communicated with, and/or made any agreements with or inducements to any other respondent relating to:
   - the intention to submit a proposal;
   - the methods or factors used to calculate the prices proposed; or
   - the respondent's proposal.

7. On behalf of itself, any parent or subordinate organization and all proposed subcontractors, the respondent accepts as lawful and binding, without reservation or limitation:
   - the RFP's submission requirements and specifications, including all RFP appendices and addenda, except as noted in the Respondent Information and Disclosure Form;
   - HHSC's procurement rules, procedures, and processes;
   - HHSC's use of the evaluation methodology and process described in RFP Section 5;
   - HHSC's sole, unrestricted right to reject any or all proposals, or parts thereof, submitted in response to the RFP;
   - the substantive, professional, legal, procedural, and technical propriety of the RFP Scope of Work.

8. The respondent generally releases from liability and waives all claims against any party providing information about the respondent at HHSC's request.

9. Prior to assigning any personnel to perform any part of its obligation under the contract, the respondent agrees that it will require its personnel and subcontractor personnel to execute individual confidentiality agreements, which upon execution will become part of the contract.

10. The respondent does not have personal or business interests that present a conflict of interest with respect to the RFP and resulting contract, and if applicable, the respondent has identified any potential conflicts of interest in its proposal.

11. The respondent has complied with all State of Texas and federal laws and regulations relating to the hiring of former state employees, and has disclosed all past state employment in its proposal.

12. The respondent has identified all parts of its proposal that it believes are excepted from disclosure under the Texas Public Information Act, and provided an explanation of why it believes the exceptions apply, in the Respondent Information and Disclosure.

13. Under Section 2155.004, Texas Government Code, the respondent certifies that the individual or business entity named in this bid or contract is not ineligible to receive the specified contract and acknowledges that this contract may be terminated and payment withheld if this certification is inaccurate.

14. Under Section 2155.006, Texas Government Code, the vendor certifies that the individual or business entity named in this bid or contract is not ineligible to receive the specified contract and acknowledges that this contract may be terminated and payment withheld if this certification is inaccurate.

15. Under Texas Family Code Section 231.006, relating to child support obligations, the respondent and any other individual or business entity named in this solicitation are eligible to receive the specified payment and acknowledge that this contract may be terminated and payment withheld if this certification is inaccurate.

16. The respondent will adhere to, and require its subcontractors to adhere to, Executive Order 13224, "Terrorist Financing – Blocking Property and Prohibiting Transactions with Persons Who Commit, Threaten to Commit, or Support Terrorism," effective September 24, 2004, as amended.

17. Respondent has not given, offered to give, nor intends to give at anytime hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with the submitted response.

18. The respondent acknowledges all addenda and amendments to the RFP.

Signature

Jonathan P. Andrews

Printed Name

Chief Operating Officer

Title

December 11, 2015

Date