State of Texas
County of Travis

HHSC 529-18-0077-00001

AGREEMENT BETWEEN THE
TEXAS HEALTH AND HUMAN SERVICES COMMISSION
AND
LOGISTICARE SOLUTIONS, LLC
FOR
NON-EMERGENCY MEDICAL TRANSPORTATION
MANAGED TRANSPORTATION ORGANIZATIONS SERVICES
IN MTO REGION 10

Section 1.01 Introduction

This Agreement is between the Texas Health and Human Services Commission ("HHSC"), an administrative agency within the executive department of the State of Texas, having its principal office at 4900 North Lamar Boulevard, Austin, Texas, 78751, and LogistiCare Solutions, LLC ("CONTRACTOR"), with its principal place of business at 12234 N. Interstate Hwy 35, Austin, Texas 78753.

HHSC and CONTRACTOR may be referred to in this Agreement individually as "Party" and collectively as the "Parties."

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

Section 1.02 Background and Inducements

(a) HHSC's Mission and Objectives.

CONTRACTOR acknowledges its understanding that HHSC's primary goal in engaging CONTRACTOR is to secure a qualified, financially sound, full-risk capitation Managed Transportation Organization (MTO) to provide quality, safe, timely and economical transportation services, and undertake all actions necessary to directly arrange and coordinate all nonemergency medical transportation services (NEMT) to NEMT Eligible Clients who reside in Managed Transportation Organization Region 10, using a network of providers contracted or arranged by CONTRACTOR. CONTRACTOR will arrange all these actions for a Per-Member-Per-Month (PMPM) capitated rate payment. CONTRACTOR will ensure NEMT Services are available for all NEMT Eligible Clients lacking other means of transportation to Program Eligible Services. CONTRACTOR will provide NEMT in compliance with the law and with *Frew, et al., v. Smith, et al., Civil Action No: 3:93CV65 (Frew)*. Specifically, NEMT services will satisfy requirements under the Consent Decree (CD), dated February, 1996, and the Corrective Action Orders (CAO), dated September 5, 2007.

(b) CONTRACTOR'S Experience and Qualification.

CONTRACTOR represents and warrants that CONTRACTOR has the skills, qualifications, expertise, financial resources and experience necessary to provide the services and deliverables, including call center management, reporting capabilities, administrative capabilities and NEMT experience, necessary to implement the scope of work described in this Agreement (the "Scope of Work - Services and Deliverables") and HHSC RFP No. 529-15-0002.

(c) Summary of Procurement Activities

HHSC sought and received approval to enter into this Agreement via an Emergency Purchase Justification. This Agreement incorporates HHSC RFP No. 529-15-0002 as if this Agreement was awarded as a result of that RFP.

(d) CONTRACTOR's Commitment and Understanding

In entering into this Agreement, CONTRACTOR agrees it has had the opportunity to review and understand HHSC's mission and objectives as described in this Agreement and the RFP, and, based on such review and understanding, CONTRACTOR currently has, and will maintain the financial and operational capacity to perform in accordance with the terms and conditions of this Agreement.

(i) CONTRACTOR certifies that it will comply with 42 C.F.R. § 440.170(a)(4) and all other requirements relating to Medicaid Services. Any material changes to how CONTRACTOR provides nonemergency medical transportation (NEMT) services under this Agreement must be approved by HHSC prior to such change.

(ii) CONTRACTOR certifies that it complies with all conflicts of interest and referral requirements implemented under Social Security Act §1902(a)(70)(B)(iv).

(iii) CONTRACTOR certifies that it will serve as a broker and will not directly provide NEMT services, as required by 42 C.F.R. 440.170(a)(4)(ii)(A). This includes prohibition against any direct or indirect ownership or control of a fleet, including through an Affiliate or party-in-interest.

(iv) CONTRACTOR certifies that it will not subcontract or make a referral to an entity with which the CONTRACTOR has a prohibited relationship under 42 C.F.R. 440.170(a)(4)(ii)(A).

(v) CONTRACTOR acknowledges that the cost of services resulting from a prohibited referral or subcontract under 42 C.F.R. § 440.170(a)(4)(ii)(A) will be an unallowable cost on the MTO Financial Statistical Report and may be subject to liquidated damages and possible interest expense.

(vi) CONTRACTOR certifies that it is not an organization or entity that may or must be excluded from participation in the Texas Medicaid Program under Social Security Act §§ 1902(p), 1128, or 1128A.

(vii) CONTRACTOR commits to maintaining these qualifications and status throughout the term of the Agreement.

Section 1.03 Agreement Elements

The Agreement between the Parties will consist of the documents listed in this Section. In the event of any conflict or contradiction between or among the Agreement elements, the documents will control in the following order of precedence:

(1) This Agreement between the Texas Health and Human Services Commission and CONTRACTOR for Non-Emergency Medical Transportation Managed Transportation Organization Services;

(2) HHSC's Request for Proposals # 529-15-0002, and its Addenda and Attachment, as supplemented and modified (collectively, the RFP, attached hereto and incorporated by reference as Exhibit F);

(3) HHSC's Data Use and Business Associate Agreement v. 8.3, (attached hereto and incorporated by reference as Exhibit D);

(4) HHSC's Uniform Terms and Conditions (UTC), version 1.5; specifically including Special Terms and Conditions 16.01, 16.02, 16.04, 16.05 and 16.08, (attached hereto and incorporated by reference as Exhibit A);

(5) Executed Performance Bond in the amount of FIFTY THOUSAND DOLLARS ($50,000.00) (attached hereto and incorporated by reference as Exhibit B);

(6) Executed Parent Guarantee (attached hereto and incorporated by reference as Exhibit C), if applicable;

(7) Definition additions, modifications and deletions to those in RFP Attachment B (attached hereto and incorporated by reference as Exhibit E);

(8) Map of Texas Managed Transportation Organization Regions (attached hereto and incorporated by reference as Exhibit G);

(9) HHSC's Cost Principles (as included in the RFP as Attachment K thereto), and as may be modified by HHSC (attached hereto and incorporated by reference as Exhibit H);

(10) The Encounter Data format as required/described in TMHP 837P Health Care Claim, the TMHP Companion Guide and, the MTO Encounter Submission Guidelines (attached hereto and incorporated by reference as Exhibit I);

(11) HHSC's MTO Financial Statistical Report (FSR) template and instructions (as included in the RFP as Attachment L thereto), and as may be modified periodically by HHSC (pursuant to 1.10.01(e) of this Agreement), and any corresponding FSR Instructions as may be provided by HHSC (attached hereto and incorporated by reference as Exhibit J);

(12) Revised Performance Standards and Liquidated Damages (modification of RFP Attachment S), (attached hereto and incorporated by reference as Exhibit K); and

(13) The Capitation Rates, (attached hereto and incorporated by reference as Exhibit L).

Section 1.04 Term of the Agreement

The Agreement shall commence on September 1, 2017, or upon the signature date of the latter of the Parties to sign the Agreement and will terminate on August 31, 2018, unless terminated sooner or extended pursuant to the terms and conditions of this Agreement.

Section 1.05 Project Managers

The following Project Managers will serve as the primary contacts for all administrative issues:

CONTRACTOR:
Steven Feist
Project Director
12234 N. Interstate Hwy 35, Bldg. B, Suite 175
Austin, Texas 78753
(877) 564-9833 (facsimile)
E-mail: stevenf@logisticare.com

HHSC:
Joey Herrera
Contract Manager
Texas Health and Human Services Commission
Medical Transportation Program
P.O. Box 149030
Austin, Texas 78714-9030
Mail Code 0209
Phone: (512) 706-4973
Facsimile: (512) 706-4997
E-mail: Joey.Herrera@hhsc.state.tx.us

Section 1.06 Notices

(a) Delivery of Notice

Any notice or other legal communication required or permitted to be made or given by either Party pursuant to this Agreement will be in writing and deemed to have been duly given:

(i) Three (3) business days after the date of mailing if sent by registered or certified U.S. mail, postage prepaid, with return receipt requested;

(ii) When transmitted if sent by facsimile, provided a confirmation of transmission is produced by the sending machine; or

(iii) When delivered if delivered personally or sent by express courier service.

(b) Routine and Administrative Notices

Any communications/notices that are routine and administrative in nature may be transmitted via electronic mail.

(c) Notice to CONTRACTOR

Any notice under this Agreement will be sufficient if delivered to the following persons or their successors.

(i) Communications that are routine and administrative in nature should be sent to the Project Managers identified in Section 1.05.

(ii) Legal notices should be sent to the following:

CONTRACTOR:
LogistiCare Solutions, LLC
Albert Cortina
1275 Peachtree Street NE 6th FL
Atlanta, GA 30309
(404) 888-5800
(404) 888-5999 (facsimile)
e-mail: albertc@logisticare.com

HHSC:
Charles Smith, Executive Commissioner
Health and Human Services Commission
4900 North Lamar Blvd.
Austin, Texas 78751
(512) 424-6586 (facsimile)

With Required Copy to:
Karen Ray, Chief Counsel
Health and Human Services Commission
4900 North Lamar Blvd.
Austin, Texas 78751

(d) Change of Designee

Either Party may change the above-referenced designees or address with five (5) days' written notice to the other Party's Project Manager shown in Section 1.05.

Section 1.07 Laws and Regulations Governing the Administration of the Agreement

The Parties will administer the Agreement in accordance with state and federal law and policy; court-ordered consent decrees and corrective action orders; and the Texas State Plan for Medical Assistance—as amended or modified during the term of the Agreement—including all applicable provisions of the following:

(1) Title XIX of the Social Security Act, including Social Security Act § 1902(a)(70), and any final regulations promulgated thereunder;

(2) Texas Government Code Chapters 531 and 533, including Texas Government Code §§ 531.02414 and 533.00257, and any administrative rules adopted thereunder;

(3) Texas Human Resources Code Chapter 32 and any administrative rules adopted

thereunder;

(4) Texas Government Code § 2155.144;

(5) 1 Tex. Admin. Code Chapter 380;

(6) 42 C.F.R. § 440.170;

(7) 42 C.F.R. § 431.53;

(8) The anti-kickback provisions of 42 U.S.C. § 1320a-7b(b);

(9) The Civil False Claims Act, 31 U.S.C. § 3729;

(10) Consent Decree and Corrective Action Orders, *Frew, et al. v. Smith, et al.*;

(11) The law listed or cited in RFP No. 529-15-0002; and

(12) Any other applicable provisions of state or federal law.

Section 1.08 Laws and Regulations Governing the Procurement of the Services

It is the express intention of the Parties that this Agreement be a procurement of services meeting all applicable requirements of the following:

(1) 45 C.F.R. Parts 74 and 92;

(2) Texas Government Code § 2155.144;

(3) 1 Tex. Admin. Code Chapters 391 and 392; and

(4) Any other applicable provisions of state or federal law.

Section 1.09 Scope of Work -- Services and Deliverables

CONTRACTOR will take all actions necessary to directly arrange and coordinate all NEMT services required under RFP No. 529-15-0002, (except for the requirements under RFP Section 2.3.9) to NEMT Eligible Clients who are deemed by HHSC as living in Managed Transportation Organization Region 10, using a network of providers contracted or arranged by the CONTRACTOR, attempting to contract with medical transportation providers that are considered significant traditional providers as defined by HHSC rule. CONTRACTOR will provide all Services and Deliverables described in this Agreement, and the RFP. The Scope of Work includes such support and resources as are necessary to produce and deliver the Services and Deliverables. CONTRACTOR is expected to meet or exceed all HHSC objectives and standards, as set forth in the RFP and this Agreement.

In addition to requirements described in the RFP and its attachments, the following are added to the scope of work:

(a) Individual Transportation Participants.

Section 2.3.3 of the RFP is replaced in its entirety with the following:

Individual Transportation Participant (ITP) services are provided by individuals who

volunteer to participate by entering into a participation agreement with the MTO. This service allows the flexibility for individuals to transport clients in personal cars to health care appointments. The MTO will be responsible for reimbursing individuals for mileage at the HHSC established rate if a program-eligible client is driven to a health care appointment in a personal car. The MTO must establish and describe in their response how it will implement ITP services for enrolled ITPs in the MTO Region in which they provide transportation services, including the qualifications needed for the safe transport of clients in accordance with state and federal laws.

(b) Insurance requirements and background checks for Individual Transportation Participants (ITP) under the RFP are supplemented as follows:

(i) ITPs that transport themselves or family member(s) only: (i) must have and maintain the minimum insurance coverage as required by State law, and (ii) must have a valid driver's license.

(ii) ITPs who transport non-family members: (i) are subject to the Standards for Motor Vehicle Operators in RFP 2.9.4 (as replaced in its entirety in (d) below), (ii) must have and maintain the minimum insurance coverage as required by State law, and (iii) must have a valid driver's license.

(c) Nonemergency Ambulance Transportation Services

Section 2.3.9 of the RFP is removed. Nonemergency Ambulance Transportation Services will not be provided by the MTOs under this Agreement.

(d) RFP Section 2.9.4 is replaced in its entirety by the following:

2.9.4 Standards for Motor Vehicle Operators

For any motor vehicle operator providing or seeking to provide transportation services through the MTO, the MTO must:

2.9.4.1 Check the driving record information of the motor vehicle operator that is maintained by the Department of Public Safety (DPS) pursuant to Texas Transportation Code, Chapter 521, Subchapter C.

2.9.4.1.1 Verify that the motor vehicle operator has a valid driver's license. A motor vehicle operator without a valid driver's license may not provide transportation services under the Agreement.

2.9.4.1.2 Ensure that a motor vehicle operator who has more than one moving violation either on or off the job within a twelve (12) month time period may not provide transportation services under the Agreement.

2.9.4.1.3 Ensure that a motor vehicle operator does not have any findings by a law enforcement authority of driving while intoxicated (DWI/DUI) or under the influence of any substance that may impair the driver's ability to safely operate a motor vehicle within seven (7) years prior to the initial hire date or any time after the hire date. Any driver who is convicted of DWI/DUI after the hire

date is immediately ineligible to provide services under the Agreement for a period of seven (7) years after the date of conviction.

2.9.4.2 The MTO shall conduct or cause to be conducted for each new employee, Performing Provider, employee of a performing provider, or driver, who works directly with clients under the contract, or who have direct access to client records, a nationwide criminal history background check, and a National and State Sex Offender Registry check, which shall be maintained by the MTO, available for review by the HHSC.

2.9.4.2.1 Conviction or convicted--Means that:

(A) a judgment of conviction has been entered against an individual or entity by a federal, state, or local court, regardless of whether:

(i) there is a post-trial motion or an appeal pending; or

(ii) the judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;

(B) a federal, state, or local court has made a finding of guilt against an individual or entity;

(C) a federal, state, or local court has accepted a plea of guilty or nolo contendere by an individual or entity; or

(D) an individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

A person on deferred adjudication is considered convicted, and therefore barred from providing services under this contract, until successful completion of deferred adjudication.

2.9.4.2.2 Ensure drivers do not have a felony or misdemeanor conviction within seven (7) years prior to the initial hire date or any time after the hire date of:

2.9.4.2.2.1 an act of abuse, neglect or exploitation of children, the elderly or persons with disabilities as defined in Texas Family Code, as amended, Chapter 261 and Texas Human Resources Code, as amended, Chapter 48; or

2.9.4.2.2.2 an offense under the Texas Penal Code, as amended, against the person; against the family; against public order or decency; against public health, safety or morals; against property; an offense under Chapter 481 of the Texas Health and Safety Code, as amended, (Texas Controlled Substances Act); and

2.9.4.2.2.3 drivers must not have been found to have conducted or participated in any acts prohibited by the Texas Human Resources Code Chapter 36.

2.9.4.2.3 Individuals with any criminal conviction that falls within the aforementioned categories that occurred within seven (7) years prior to the hire date or any time after the hire date shall not be allowed to participate in providing services under the Agreement and any services that are determined to have been provided by a person not eligible to provide services under the Agreement will be subject to liquidated damages.

2.9.4.3 Drivers must not solicit or accept money, goods or additional business from clients.

2.9.4.4 Drivers must meet federal guidelines for HIPAA compliance by keeping all client protected health information (PHI) confidential.

2.9.4.5 The MTO must ensure that all drivers are at least 18 years of age.

(e) Section 2.12.1.3 of the RFP is clarified with the following:

The MTO must obtain and maintain at least seven hundred and fifty thousand dollars ($750,000) combined single limit Business Auto Insurance with Combined Single Limit of $750,000 bodily injury per person, bodily injury per accident, property damage per accident is a requirement for owned, non-owned and hired automobiles.

As such, $750,000 combined single limit is the minimum requirement that all Performing Providers must carry, whether they are the MTO's owned fleet, hired or contracted by the MTO.

The intent of RFP 2.12.2 is the additional requirement that Performing Providers comply with all Federal, State and Local insurance laws.

(f) Training

Additional Training requirements

RFP Attachment E - Training Requirements is amended to add/include the following trainings:

Training Required	**Training Period**
Emergency Procedures for Transportation Providers	Annually
Universal Precautions for blood borne pathogens	Every 2 years
Use of Fire Extinguisher	Annually
Wheelchair transfer and securing of wheelchair in vehicle	Annually
Completion of Driver Log	Every 2 years
Culture Diversity Training	Every 2 years

(g) Reports

(i) Additional Contract Required Reports

RFP Attachment J - Contract Required Reports is amended to add/include the following:

Report to HHSC	Reporting Method	Due to HHSC
HHSC Telecommunication Assets	Format and Media Prescribed	On September 3 of each year
Financial and Related reports (as described in the RFP and its attachments)	Format and Media Prescribed	As indicated in the RFP
Administrative and Related reports (as described in the RFP and its attachments)	Format and Media Prescribed	As indicated in the RFP

(ii) Report Requirements that Replace Certain Requirement in RFP Attachment J

RFP Attachment J - Contract Required Reports is amended as follows:

The following reporting requirements replace the language posted in the RFP:

Report to HHSC	Reporting Method	Due to HHSC
Encounter Data Report (RFP Section 2.28)	Format and Media Prescribed	Monthly to the Claims Administrator by the 30th day of the following month or otherwise instructed by HHSC.

(h) Additional Network File Requirements.

(i) Performing Provider Network File New Requirements

The MT88 MTO Network File is to gather information about the MTO's Performing Provider network to match against information from the Claims Administrator's MTO Combined Master Provider File and the Texas Department of Public Safety Driver's License database to assure that only enrolled and qualified providers/participants are rendering services to eligible MTP clients.

An MTO must submit their MT88 MTO Network File, which contains data detailing Performing Providers contracting with the MTO for their plan.

(ii) File Submission Requirements

The MTO must submit all Performing Providers on the network file to the Claims Administrator twice a month. The file must contain all Performing Providers with an active effective date on each submission, regardless if the Performing Providers render services within the reporting period.

(iii) File Format and Testing Requirements

The MTO must submit all the HHSC required data elements for this network file in the prescribed format. The MTO must conduct trading partner testing with the Claims Administrator on the MT88 MTO Network File when the infrastructure becomes available for testing and prior to submitting a file to production.

(iv) **MTO Performing Providers**

(1) The MTO must enroll all Performing Providers that will be part of the MT88 MTO Network File through their enrollment and credentialing process and enter into a written agreement with the MTO.

(2) Ensure that all Performing Providers are properly enrolled through the Claims Administrator prior to providing services under the Agreement.

(v) **File Validity Checks**

The MTO must report all Performing Providers on their MT88 MTO Network File. HHSC will perform a validity check on the Performing Providers' drivers' licenses each time the MT88 MTO Network File is submitted to the Claims Administrator. The MTO is responsible for retrieving the drivers' license response file from their TXMedCentral folder.

If an MTO uses a Performing Provider not listed in the MTO Combined Master Provider File or not fully enrolled through the MTO's enrollment process, any cost of services attributable to such Performing Provider will be deemed an unallowable cost for FSR reporting (and may be subject to Liquidated Damages and interest expense assessments).

(vi) **General Requirement**

The MTO is responsible for uploading and downloading all required files in TXMedCentral, which is accessed through a secured file transfer protocol (SFTP), for managing services under the contract.

(i) RFP Section 2.7.9, MTO Responsibilities, is supplemented as follows:

CONTRACTOR will use the HHS Enterprise Administrative Report and Tracking System (HEART), a web-based application, to track and monitor complaints and compliments, document complaint resolutions, and generate reports to assess timeliness and service trends.

Section 1.10 Terms & Conditions of Payment

Section 1.10.01 Calculation of monthly Capitation Payment

(a) This is a risk-based contract. HHSC will pay CONTRACTOR fixed monthly Capitation Payments based on 1) the number of NEMT Eligible Clients that reside in CONTRACTOR's Region, and, 2) the Per-Member-Per-Month (PMPM) Rates, as set by HHSC's actuaries for each class of Eligible Client hereunder. Thus, aggregate monthly payments to CONTRACTOR will fluctuate primarily in response to 1) monthly fluctuations in the number of Eligible Clients hereunder (as determined by HHSC), and, 2) any changes in Rates (which are usually annual changes).

HHSC payments to the CONTRACTOR do *not* generally fluctuate according to, or in response to, the level of costs incurred by CONTRACTOR. CONTRACTOR does not invoice HHSC; HHSC determines the number of Eligible Clients each month, and then applies the Capitation Rate to each class of Client, and calculates the aggregate monthly Capitation Payment, which HHSC then remits to CONTRACTOR. In general, CONTRACTOR does *not* bill for extra costs, etc.

HHSC will calculate the monthly Capitation Payments by multiplying the number of NEMT Eligible Clients in each Rate Cell by the applicable fixed Capitation Rate for each Rate Cell, as further described in Section 1.10.04. In consideration of the monthly Capitation Payment, CONTRACTOR agrees to provide the Services and Deliverables described in this Agreement. In general, CONTRACTOR is at-risk for all expenses that may be necessary or incurred in order to deliver contractually required Services, even if such expenses are in excess of the monthly Capitation Payments received.

(b) The fixed monthly Capitation Rate consists of the following components:

(i) an amount for NEMT Services provided to NEMT Eligible Clients during the month;

(ii) an amount for administering the program, and

(iii) an amount for CONTRACTOR's Risk margin.

Capitation Rates may vary by Rate Cell, by Region, and/or by Rate Period. HHSC will employ or retain qualified actuaries to perform data analysis and calculate the Capitation Rates for each Rate Period. Rates will be determined under the rate setting process described in this section.

(c) CONTRACTOR will be required to provide timely financial and statistical information necessary in the Capitation Rate determination process. Financial Statistical Report (FSR) and Encounter Data provided by CONTRACTOR must conform to all HHSC requirements. FSR and Encounter Data containing non-compliant information, including, but not limited to, inaccurate client or member identification numbers, inaccurate transportation provider identification numbers, or services codes insufficient to adequately describe the services provided, may not at HHSC discretion be considered in CONTRACTOR's experience for rate-setting purposes. This could result in setting rates at lower levels.

The FSR is due to the MTP Financial Analyst (or to HHSC's designated agent) by no later than 30 days following the end of quarters 1, 2 and 3, and 45 days after the 4th quarter. The final FSR is due 120 days after the end of the state fiscal year. All FSRs are generally audited thereafter. (Note that not all incurred costs are allowable for inclusion in the FSR; see HHSC's Cost Principles). FSRs are submitted via email to specified HHSC staff in the form of locked MS Excel files. HHSC will inform CONTRACTOR of specific staff email addresses for this purpose. FSRs may be posted on HHSC's website.

Certain other information or data, including complete and accurate Encounter Data, as requested by HHSC for reporting and/or rate-setting purposes, must be provided to the HHSC Claims Administrator (or its designated agent) monthly by the 30th day of the following month, or as otherwise instructed by HHSC.

(d) CONTRACTOR understands and agrees that it will serve as a broker MTO and will not directly provide NEMT services, in compliance with 42 C.F.R. 440.170(a)(4)(ii)(A). This includes prohibition against any direct or indirect ownership or control of a fleet, including through an Affiliate or party-in-interest, and/or through drivers who may be either employees or captive independent contractors. Usage of any such fleet hereunder materially violates the terms of this Contract, and may result in termination or other remedies as may be available, Liquidated Damages (LDs), disallowing of expenses, and/or an assessment of interest expense.

(e) CONTRACTOR understands and agrees that there may be changes to the FSR format, the FSR Instructions, the Cost Principles, required reports, and/or related documentation. HHSC will afford CONTRACTOR 30 calendar days to review and respond to any such proposed changes, whereby the CONTRACTOR may suggest edits or alternatives to HHSC's changes, seek clarification, and make comments as to potential impacts of such changes, etc. HHSC will give careful consideration to such suggestions and comments received, but is not obligated to alter its changes. CONTRACTOR agrees that such changes are not material to the Agreement and do not need a formal Amendment. CONTRACTOR agrees that it will comply with such change requests.

(f) CONTRACTOR understands and expressly assumes the risks associated with the performance of the duties and responsibilities under this Agreement, including the failure, termination or suspension of funding to HHSC, delays or denials of required approvals, and cost overruns.

Section 1.10.02 Time and Manner of Payment

(a) This is a risk-based contract, which means that CONTRACTOR is at-risk for expenses that may be necessary or incurred in order to deliver contractually-required Services and Deliverables, even if such expenses are in excess of the Capitation Payments received. This is not a reimbursement-based contract.

(b) CONTRACTOR is responsible for all required Non-Emergency Medical Transportation (and any related lodging and/or meals) for all the Eligible Clients deemed by HHSC to be residents of the CONTRACTOR'S MTO Region as awarded hereunder. This includes services both within and outside of the Region. CONTRACTOR does not get to choose where the Client is transported to. This means that, for no additional compensation/reimbursement, CONTRACTOR must also provide travel arrangements and transportation for Eligible Clients living in CONTRACTOR's Region when those Clients must travel outside that Region for authorized treatment.

(c) HHSC has , at its own expense (on a one-time basis), caused its agents to install AT&T line, plus wiring, servers, server rack, secure cabinet, and phones, as described in the RFP, necessary to support the telecom "Cloud Solution." HHSC will provide additional phones at the current location to ensure the Contactor can adequately handle call volume for scheduling, arranging, and providing services under the terms of the Contract. Subsequent costs related to modification or relocation of this provided infrastructure, caused by CONTRACTOR moves, facility changes, or facility damages or loss, etc., will be solely at CONTRACTOR's expense.

HHSC installed routers on-site are an HHSC owned asset with an asset tag. All other HHSC installed equipment will not have an asset tag but is part of the HHSC inventory at each location. The MTO will be required to submit an inventory list annually to HHSC. The MTO may not install other equipment or data ports in the HHSC installed secure cabinet.

All such assets are the property of the State of Texas, and shall remain so throughout the term of the Agreement. Contractor shall relinquish such equipment to HHSC upon termination.

(d) During the Agreement Term, HHSC will pay the monthly Capitation Payment by the 10th Business Day of each calendar month. The monthly Capitation Payments are made prospectively, based on NEMT Eligible Clients.

(e) CONTRACTOR must accept the Capitation Payment by direct deposit into CONTRACTOR's account.

(f) See section 1.10.6 below for possible adjustments to Capitation Payments

(g) HHSC's payment of the monthly Capitation Payment is subject to availability of federal and state appropriations and funds. If appropriations and funds are not available to pay the full monthly Capitation Payment, HHSC may:

(i) equitably adjust the Capitation Payment for CONTRACTOR, and reduce the scope of service requirements as appropriate in accordance UTC v. 1.5 Section 7.01, or

(ii) terminate the Agreement in accordance with the Article 11 of UTC v. 1.5 ("Remedies and Disputes").

Section 1.10.03 Modification of Capitation Rates

(a) The Parties expressly understand and agree that agreed Capitation Rates will generally change on an annual basis, or as otherwise deemed appropriate by HHSC, and are subject to modification if changes in state or federal laws, rules, regulations or policies affect the rates, or required Services. HHSC will provide CONTRACTOR notice of a modification to the monthly Capitation Rates or Services, sixty (60) days prior to the effective date of the change, unless HHSC reasonably determines that circumstances warrant a shorter notice period.

(b) If, under (a) above, HHSC proposes a modification to the Capitation Rate or Services that is unacceptable to CONTRACTOR, CONTRACTOR may request a modification of the Agreement under 1.18 below. If the parties are unable to mutually agree on an acceptable rate, CONTRACTOR may terminate the Agreement subject to 1.10.03(c) below. CONTRACTOR must submit a written notice of intent to terminate due to a change in the monthly Capitation Rates or Services no later than thirty (30) days after HHSC's notice of the proposed change. If the effective date of the termination is after the effective date of the new Capitation Rates, the new rates will apply during that period of time.

(c) In order to terminate the Agreement, pursuant to this Section, CONTRACTOR must give HHSC at least one-hundred twenty (120) days written notice of intent to terminate. The termination date will be calculated as the last day of the month following one-hundred twenty (120) days from the date the notice of intent to terminate is received by HHSC.

Section 1.10.04 Capitation Structure

(a) Rate Cells

Capitation Rates are defined on a Per-Member-Per-Month (PMPM) basis by Rate Cells and Regions. The Rate Cells are:

(1) Children - Rural
(2) Children - Urban
(3) Adults - Rural
(4) Adults – Urban
(5) CSHCN (Rural & Urban)

Note that Children herein are defined as being under 21 years of age, and Adults are age 21 and over. Urban and Rural are as defined in the RFP (see Attachment Q – HHSC classification of Counties as "urban" or "rural," with respect to non-emergency medical transportation).

Children with Special Healthcare Needs (CSHCN) are defined as those children who have been accepted into, and have enrolled in, HHSC's Program of the same name. This Rate Cell category is *not* meant to refer simply to any child that has special needs. Eligible Clients that are designated as being in this Rate Cell will be shown as such in the enrollment files provided by HHSC.

CSHCN will be paid by HHSC to CONTRACTOR at the same rate as Children – Urban hereunder. HHSC recognizes that CSHCN have different, higher services needs as compared to other Children, and that these higher needs generally cost more to meet. However, the population size for CSHCN is not large enough for HHSC's actuaries to calculate separate rates for CSHCN by Region at this time. Instead, the overall rates for Children have been adjusted slightly upward, for all Children, to accommodate and include the higher costs of providing for CSHCN. (In other words, if a special rate for CSHCN were possible to calculate separately, then the rate for other Children would need to be adjusted down slightly.)

CSHCN will be reported separately in the FSR, but will have an identical payment Rate as Children - Urban. As actual costs for servicing CSHCN are reported in the FSR, these costs are likely to appear as in excess of the capitation payments shown for them. However, in total, HHSC believes that the aggregate Capitation paid for Children and CSHCN combined will be actuarially sound. At some point HHSC may be able to provide a distinct rate for CSHCN.

In specific counties in Texas Managed Transportation Organization Region 10, there is an additional group of people who are provided non-emergency medical transportation benefits. These are certain indigent cancer patients. These people, in the one Managed Transportation Organization Region where applicable, will be combined in with the CSHCN population for rate setting purposes. The specific counties where this is applicable are Willacy, Cameron, Hidalgo, Starr, Jim Hogg, Zapata, Webb and Nueces. In this one Region, the actual expenses for the indigent cancer patients will be reported in the CSHCN line item on the FSR.

(b) Capitation Rate development

(i) Rate Periods.

A Rate Period is usually a State Fiscal Year (SFY). A State Fiscal Year is the twelve-month period that commences on September 1st and ends on August 31st. If the Operational Start Date of this Agreement does not commence on the first day of an SFY, then the first Rate Period may be the remaining portion of the then-current SFY. If the remaining portion of the SFY is deemed by HHSC to be a relatively short period, then, at HHSC's discretion, the first Rate Period may be the remaining portion of the SFY plus the following SFY.

(ii) Capitation Rates for subsequent Rate Periods.

HHSC will establish Capitation Rates for the Rate Periods following the initial Rate Period by analyzing historical Encounter Data and Financial Statistical Report (FSR) data for the Region. This analysis will include a review of historical enrollment and claims experience information; any changes to Program Eligible Services and NEMT Eligible

Clients; rate changes specified by the Texas Legislature; underlying specifically relevant cost inflation/deflation trends; and any other information deemed relevant by HHSC.

Section 1.10.05 CONTRACTOR input during rate setting process

(a) HHSC will develop a rate setting timeline, and will communicate with CONTRACTOR regarding data submissions, meetings, preliminary Capitation Rates, and other information. Final Capitation Rates will be provided to CONTRACTOR prior to the commencement of next Rate Period. For subsequent Rate Periods, the pattern will be similar, with rates developed and set during the latter part of a SFY, and made available to CONTRACTOR prior to the commencement of the new Rate Period.

(b) CONTRACTOR must provide certified Encounter Data as described in Exhibit J and financial data as set forth in the FSR. Such information may include, without limitation: claims lag information by Rate Cell, purchased services expenses, administrative expenses, and Affiliate transaction information. HHSC may request clarification or additional financial information from CONTRACTOR. HHSC will notify CONTRACTOR of the deadline for submitting a response, which will include a reasonable amount of time for response.

(c) HHSC will allow CONTRACTOR to review and comment on data used by HHSC to determine base Capitation Rates. HHSC will notify CONTRACTOR of deadline for submitting comments, which will include a reasonable amount of time for response. At its discretion, HHSC may not consider comments received after the deadline in its rate analysis.

(d) During the rate setting process, HHSC will conduct at least one meeting with CONTRACTOR. HHSC may conduct the meeting in person, via teleconference, or by another method deemed appropriate by HHSC. Prior to the meeting, HHSC will provide CONTRACTOR with proposed Capitation Rates. During the meeting, HHSC will describe the process used to generate the proposed Capitation Rates, discuss major changes in the rate setting process, and receive input from CONTRACTOR. HHSC will notify CONTRACTOR of the deadline for submitting comments, which will include a reasonable amount of time to review and comment on the proposed Capitation Rates and rate setting process. After reviewing such comments, HHSC may at its discretion conduct a second meeting to discuss the final Capitation Rates and changes resulting from CONTRACTOR comments, if any.

Section 1.10.06 Adjustments to Capitation Payments

Adjustments to, and/or recoupments of, the monthly Capitated Payment may be made in accordance with Sections 6.11.5.1 and 6.11.5.2 of the RFP. As described in Section 6.11.5.3 of the RFP, CONTRACTOR may appeal the recoupment or adjustment of capitation payments using the HHSC informal dispute resolution process set forth in UTC v. 1.5 Section 11.11(a) and (b), ("Dispute Resolution").

In addition to any adjustments provided in RFP, HHSC may adjust the Capitation Payment to CONTRACTOR in the case of an overpayment to CONTRACTOR, for Experience Rebate amounts due and unpaid (including any associated interest), and if monetary damages are assessed in accordance with this Agreement and/or under Article 11 of UTC v. 1.5 ("Remedies and Disputes").

Any cost of services resulting from a referral or subcontract that is prohibited under statute or regulation will be deemed an unallowable cost for FSR reporting (and may be subject to Liquidated Damages and interest expense assessments).

Any cost of services provided by a driver employed without passing a Criminal Background and/or Sex Registry Checks will be an unallowable cost for FSR reporting (and may be subject to Liquidated Damages and interest expense assessments).

Section 1.10.07 Experience Rebate

Experience Rebate means the portion of CONTRACTOR's Net Income Before Taxes resulting from this Agreement (as defined by HHSC's MTO Cost Principles, and subject to audit by HHSC), that may be returned to HHSC in accordance with the terms herein. The Experience Rebate is a mechanism put in place as a fiduciary safeguard for the taxpayers, to limit profits that may be made by certain types of vendors that contract with HHSC. The Experience Rebate does not apply in a given State Fiscal Year if CONTRACTOR's Net Income Before Taxes (as defined by the Cost Principles) is a loss, or is no more than 5%, for that SFY.

The Experience Rebate will be administered as defined and described in The RFP, in Section 6.12, Experience Rebate. As a supplement to RFP Section 6.12, the following paragraphs are added:

With respect to RFP 6.12.2, Graduated Experience Rebate Sharing Method:

> By way of illustration only, if a contractor had $100,000 in total HHSC-related revenues for a State Fiscal Year, and if CONTRACTOR had $14,000 in Net Income Before Taxes, as defined by HHSC Cost Principles, then in this example CONTRACTOR would keep all of the first $5,000 of the Net Income Before Taxes; it would keep 60% of the next $3,000; it would keep 35% of the next $4,000; and, it would keep 15% of the last $2,000 of Net Income Before Taxes. This would total to CONTRACTOR keeping $8,500 of the $14,000; thus, a payment to HHSC for $5,500 would be due from CONTRACTOR in this example.

With respect to RFP Section 6.12.3.2, Net Income Before Taxes; Items Omitted from Calculations:

> Various other normal business expenses are unallowable, as more specifically defined by the Cost Principles (Exhibit H). These unallowable expenses include, but are not limited to, the following: interest expenses; income taxes (federal, state, or local), including state franchise taxes; bad debt expense; contributions, donations; lobbying; royalty fees, franchise fees; markups or margin by Affiliates; entertainment; alcoholic beverages; fines, penalties, damages, and settlements; bond issuance cost amortization, bond discounts; provision for contingent reserves; cost of capital; defense or prosecution of criminal proceedings, civil proceedings, and claims; investment management costs; loss on disposition of property; costs of memberships, dues and expenses associated with country club and fraternal organizations; political contributions; proposal preparation costs; and, airfare costs in excess of standard coach class. Any cost deemed unallowable if incurred directly by CONTRACTOR would also be unallowable if incurred by an Affiliate and included in amounts billed or assessed to CONTRACTOR.

Note that a cost being deemed "unallowable" does not mean that CONTRACTOR is not allowed to incur the cost; it only means that the cost may not be included in HHSC's FSR report and may not be used in computing the FSR's Net Income Before Taxes. The Cost Principles do not generally restrict the manner in which CONTRACTOR structures its business arrangements; rather, they define how a particular HHSC-defined report is to be generated. Many of the cost categories that are deemed unallowable are unallowable in Federal FAR regulations for government contracting.

Section 1.10.08 Restriction on Assignment of Fees

As provided in Section 6.13 of the RFP, during the term of the Agreement, CONTRACTOR may not, directly or indirectly, assign to any third party any beneficial or legal interest of the CONTRACTOR in or to any payments to be made by HHSC pursuant to the Agreement. This restriction does not apply to fees the CONTRACTOR pays to non-affiliated Performing Providers for the performance of the Scope of Work.

Section 1.11 Performance Remedies – Damages

(a) Performance Standards and Remedies

CONTRACTOR is expected to meet or exceed the objectives and standards set forth in this Agreement. All areas of responsibility and all requirements listed in the Agreement will be subject to performance evaluation by HHSC. Performance reviews may be conducted at HHSC's discretion at any time and may relate to any responsibility and/or requirement. Any and all responsibilities and requirements not fulfilled may be subject to the remedies set forth originally as RFP Attachment S, as subsequently modified and incorporated and attached to this Agreement as Exhibit K, and/or as provided under Article 11 of UTC v. 1.5.

(b) Assignment/Assumption of Subcontracts upon Termination for Cause

If HHSC terminates this Agreement for cause, CONTRACTOR (upon HHSC's request) must consent to assignment or assumption of any of its subcontracts, or discrete provisions thereof, for Services and Deliverables provided under this Agreement to HHSC or HHSC's designee. Any subcontracts or subcontract amendments that CONTRACTOR executes after the Effective Date of this Agreement for services under this Agreement must contain the Subcontractor's express agreement that HHSC has the foregoing option.

Section 1.12 Audits

CONTRACTOR will provide to HHSC, at no additional cost to HHSC:

(a) See Section 6.18 and Attachment P of the RFP.

(b) The requirements listed under (a) above, do not remove or modify any other audit duty or requirement that may be additionally listed as Authorized or Required Under Section 8 of the UTC v. 1.5, (Exhibit A)

Section 1.13 Requirements for CONTRACTOR's Subcontractors

In addition to or as included in the requirements of UTC v. 1.5 Section 4.05 and the RFP including RFP Sections 3.12, 3.13 or others that apply, the following conditions will apply. CONTRACTOR must:

(a) provide an updated list of all Subcontracts, not already reported pursuant to Section 1.09(e) of this Agreement.

(b) actively monitor the quality of Services, as well as the quality of reporting data, provided under a Subcontract;

(c) unless otherwise provided in this Agreement, provide HHSC with written notice no later than three (3) Business Days after receiving notice from a Material Subcontractor of its intent to terminate a Material Subcontract.

(**Note**: For definition of "Material Subcontractor [and other defined terms] see RFP Attachment B, Definitions and Acronyms.)

(d) Except as provided herein, all Subcontracts must be in writing and must provide HHSC the right to examine the Subcontract and all Subcontractor records relating to the Agreement and the Subcontract. This requirement does not apply to agreements with non-affiliate utility or mail service providers.

(e) In addition to and/or in conformance with Section 3.13 of the RFP, CONTRACTOR must submit a copy of each Material Subcontract executed prior to the Effective Date of the Agreement to HHSC no later than thirty (30) days after the Effective Date of the Agreement. For Material Subcontracts executed or amended after the Effective Date of the Agreement, CONTRACTOR must submit a copy to HHSC no later than five (5) Business Days after execution or amendment. Any change in pricing is considered to be an amendment.

(f) HHSC reserves the right to reject any Subcontract or require changes to any provisions that do not comply with the requirements or duties and responsibilities of this Agreement or create significant barriers for HHSC in monitoring compliance with this Agreement.

(g) All Subcontracts must show the expected dollar amount or the value of any consideration that CONTRACTOR pays to, or receives from, the Subcontractor. <u>All</u> Subcontracts must clearly state, near the beginning of the document, whether any parties to the agreement are Affiliates (as defined in RFP Attachment B, Definitions and Acronyms). If there are more than two parties to the agreement, then the specific parties that are affiliated to each other must be clearly stated. Further, if any parties that are not deemed to be Affiliates, but could be deemed to be "Parties-in-Interest" (as defined in RFP Attachment M, Disclosure Statement, Section B), this must be clearly stated. Note that Parties-in-Interest includes dealings, directly or indirectly, with individual persons, who may not technically be deemed to be an Affiliate. This could include, for example, the CONTRACTOR'S major shareholders, directors, officers, management, and, relatives of such persons, and, companies controlled by such persons or by relatives of such persons.

(h) Any Subcontract with an Affiliate is subject to audit by HHSC or its agents, the same as if the costs were incurred directly by the CONTRACTOR. Costs that are not allowable for

inclusion in the FSR by the CONTRACTOR are also not allowable for inclusion via billing by Affiliates. Just as the CONTRACTOR has an affirmative duty to segregate unallowable costs for reporting, so does any Affiliate in its billing to the CONTRACTOR. Any Subcontract with an Affiliate must include these terms and conditions, and must specifically allow for the auditing of relevant costs of the Subcontractor by HHSC or its designee. Any Subcontract with an Affiliate must clearly state in its beginning that the subcontracted party is an Affiliate of the CONTRACTOR. Costs billed to the CONTRACTOR by an Affiliate are subject to being disallowed from inclusion in the FSR report. See the HHSC Cost Principles for further details regarding allowable Affiliate costs, and reporting requirements.

(i) During the Agreement Term, performance reviews by HHSC or its designated agent may occur if:

(1) a new Material Subcontractor is employed by CONTRACTOR;
(2) an existing Material Subcontractor provides services in a new MTO Region;
(3) an existing Material Subcontractor provides services for a new CONTRACTOR program;
(4) an existing Material Subcontractor changes locations or changes its operational functions;
(5) an existing Material Subcontractor changes one or more of its claims processing or operational functions; or
(6) a review is requested by HHSC. The CONTRACTOR must submit information required by HHSC for each proposed Subcontractor.

(j) For any new Material Subcontractor that is engaged after the Effective Date of the Agreement, the CONTRACTOR must substantiate to HHSC's satisfaction the proposed Material Subcontractor's ability to perform the subcontracted Services, and certify to HHSC that no loss of service will occur as a result of the performance of such Subcontractor. CONTRACTOR will assume responsibility for all contractual responsibilities whether or not CONTRACTOR directly performs them. Further, HHSC considers CONTRACTOR to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the Agreement.

(k) A Subcontract whereby CONTRACTOR receives rebates, recoupments, discounts, payments, or other consideration from a Subcontractor (including without limitations Affiliates) pursuant to or related to the execution of this Agreement must be in writing and must provide HHSC the right to examine the Subcontract and all records relating to such consideration.

(l) In compliance with 42 C.F.R. § 438.230:

(1) CONTRACTOR will oversee and is accountable for any functions and responsibilities that it delegates to any subcontractor.
(2) Before any delegation, CONTRACTOR will evaluate the prospective subcontractor's ability to perform the activities to be delegated.
(3) CONTRACTOR will have a written agreement with the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

(4) CONTRACTOR will monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or state laws and regulations. If the CONTRACTOR identifies deficiencies or areas for improvement, the CONTRACTOR and the subcontractor must take corrective action.

Section 1.14 NEMT Eligibility & Enrollment

The State or its designee will identify a client's health program's eligibility for HHSC NEMT. (See RFP Section 2.7.2.6) The MTO is responsible for checking NEMT eligibility and determining if the trip to the healthcare appointment is covered by the respective health program. (See RFP Section 2.7.2.4.)

HHSC makes no guarantees or representations to CONTRACTOR regarding the number of NEMT Eligible Clients who will ultimately be enrolled in CONTRACTOR's Region or the length of time any such enrolling NEMT Eligible Clients remain enrolled. (See RFP 2.7.2.6)

Section 1.15 Financial Assurance

(a) Performance Bond

For each operational year under this Agreement, the CONTRACTOR must obtain a performance bond with a one (1) year term. The performance bond must be renewable and renewal must occur no later than the first day of each subsequent State Fiscal Year. The performance bond must continue to be in effect for six (6) months following the expiration of the final renewal period. CONTRACTOR must obtain and maintain the performance bonds in the form prescribed by HHSC and (i) approved by the Texas Department of Insurance (TDI) (ii) or issued by an entity approved, in writing, by HHSC, naming HHSC as Obligee, securing CONTRACTOR's faithful performance of the terms and conditions of this Agreement. The performance bonds will be executed in compliance with the relevant provisions of the Texas Insurance Code. At least one performance bond must be issued. The amount of the performance bond(s) should total $50,000.00. Performance bonds must be issued by (i) a surety licensed by Texas Department of Insurance (TDI) or (ii) by an entity approved, in writing, by HHSC, and specify cash payment as the sole remedy. Failure to maintain the bond in effect during each fiscal year is a material breach of the Agreement. (Initial Bond is Exhibit B to this Agreement).

(b) Parent Guarantee

CONTRACTOR's Parent Guarantee must be on a form provided or accepted by HHSC, and attached hereto as Exhibit C.

Section 1.16 Prohibition Against Performance Outside the United States

(a) Findings

(i) HHSC finds the following:

(1) HHSC is responsible for administering several public programs that require the collection and maintenance of information relating to persons who apply for and receive services from HHSC programs. This information consists of, among other things, personal financial and medical information and information designated "Confidential Information" under state and federal law and this Agreement. Some of this information may, within the

limits of the law and this Agreement, be shared from time to time with CONTRACTOR or a subcontractor for purposes of performing the Services or providing the Deliverables under this Agreement.

(2) HHSC is also responsible for collecting and maintaining personal information, including personal financial and medical information, concerning persons employed by HHSC and other health and human services agencies. Some of this information may be shared from time to time with CONTRACTOR or a subcontractor or collected and maintained by CONTRACTOR or a subcontractor for purposes of performing the Services or providing the Deliverables under this Agreement.

(3) HHSC is legally responsible maintaining the confidentiality and integrity of information relating to applicants and recipients of HHSC services and employees of HHS agencies and ensuring that any person or entity that receives such information, including CONTRACTOR and any subcontractor, is similarly bound by these obligations.

(4) HHSC also is responsible for the development and implementation computer software and hardware to support HHSC programs. These items are paid for, in whole or in part, with state and federal funds. The federal agencies that fund these items maintain a limited interest in the software and hardware so developed or acquired.

(5) Some of the software used or developed by HHSC may also be subject to statutory restrictions on the export of technology to foreign nations, including but not limited to the Export Administration Regulations, 15 C.F.R. Parts 730-774.

(ii) In view of these obligations, and to ensure accountability, integrity, and the security of the information maintained by or for HHSC and the work performed on behalf of HHSC, **HHSC DETERMINES THAT IT IS NECESSARY AND APPROPRIATE TO REQUIRE THAT:**

(1) ALL WORK PERFORMED UNDER THIS AGREEMENT MUST BE PERFORMED EXCLUSIVELY WITHIN THE UNITED STATES; AND

(2) ALL INFORMATION OBTAINED BY CONTRACTOR OR A SUBCONTRACTOR UNDER THIS AGREEMENT MUST BE MAINTAINED WITHIN THE UNITED STATES.

(iii) Further, HHSC finds it necessary and appropriate to forbid the performance of any work or the maintenance of any information relating or obtained pursuant to this Agreement to occur outside of the United States except as specifically authorized or approved by HHSC.

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

(i) As used in this Section 1.16, 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.

(ii) 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.

(c) Maintenance of Confidential Information

(i) 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.

(ii) 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.

(d) Performance of Work under Agreement

(i) Unless otherwise approved in advance by HHSC in writing, and subject to the exceptions specified in paragraph (e) of this Section 1.16, CONTRACTOR and all subcontractors, vendors, agents, and service providers of or for CONTRACTOR must perform all services under the Agreement, including all tasks, functions, and responsibilities assigned and delegated to CONTRACTOR under this Agreement, within the United States.

(1) This obligation includes, but is not limited to, all Services, including but not limited to information technology services, processing, transmission, storage, archiving, data center services, disaster recovery sites and services, customer support, medical, dental, laboratory and clinical services.

(2) All custom software prepared for performance of this Agreement, and all modifications of custom, third party, or vendor proprietary software, must be performed within the United States.

(ii) Unless otherwise approved in advance by HHSC in writing, and subject to the exceptions specified in paragraph (e) of this Section 1.16, CONTRACTOR and all subcontractors, vendors, agents, and service providers of or for CONTRACTOR must not permit any person to perform work under this Agreement from a location outside the United States.

(e) Exceptions

(i) COTS Software. The foregoing requirements will not preclude the acquisition or use of commercial off-the-shelf software that is developed outside the United States or hardware that is generically configured outside the United States.

(ii) Foreign-made Products and Supplies. The foregoing requirements will not preclude CONTRACTOR from acquiring, using, or reimbursing products or supplies that are manufactured

outside the United States, provided such products or supplies are commercially available within the United States for acquisition or reimbursement by HHSC.

(iii) HHSC Prior Approval. The foregoing requirements will not preclude CONTRACTOR from performing work outside the United States that HHSC has approved in writing and that HHSC has confirmed will not involve the sharing of Confidential Information outside the United States.

(f) Disclosure

CONTRACTOR must disclose all Services and Deliverables under or related to this Agreement that CONTRACTOR intends to perform or has performed outside the United States, whether directly or via subcontractors, vendors, agents, or service providers.

(g) Remedy

(i) CONTRACTOR's violation of this Section 1.16 will constitute a material breach in accordance with UTC v. 1.5, Section 11.02. CONTRACTOR will be liable to HHSC for all actual and consequential damages in accordance with the HHSC Uniform Contract Terms and Conditions.

(ii) For breach of the requirements under this Section 1.16, HHSC may terminate the Agreement with Notice to CONTRACTOR at least 1 calendar day before the effective date of such termination.

Section 1.17 Publicity

UTC v. 1.5, Section 3.08(a) is modified as follows only as necessary to implement the requirements of this Agreement. CONTRACTOR may use the name of HHSC, the State of Texas, any HHS Agency, and the name of the Medical Transportation Program in any media release, public announcement, or public disclosure relating to the Contract or its subject matter only if, at least fifteen (15) business days prior to distributing the material, CONTRACTOR submits the information to HHSC and receives HHSC approval. If HHSC has not responded within fifteen (15) business days, use is denied. HHSC reserves the right to object to and require changes to the publication if, at HHSC's sole discretion, it determines that the publication does not accurately reflect the terms and goals of the Contract or CONTRACTOR's performance under the Agreement. CONTRACTOR will provide HHSC with one (1) electronic copy of any information prior to public release. CONTRACTOR will provide additional copies, including hard copies, at the request of HHSC.

Section 1.18 Business Plan for Negotiating Amendments

This Section 1.18 represents the Parties' Business Plan for negotiating amendments to the Agreement, as required by Article 7 of HHSC's Uniform Contract Terms and Conditions.

(a) Formal Amendment Procedure

All modifications to the Agreement, other than periodic capitation rate-changes as set forth in Section 1.10 above, must be accomplished through the formal amendment process set forth herein.

(i) HHSC or CONTRACTOR may propose changes in the Services, Deliverables, or other aspects of this Agreement.

(ii) 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 five (5) business days. The response must specify:

(1) 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;

(2) 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;

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

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

(iii) If HHSC accepts CONTRACTOR's response, CONTRACTOR must indemnify and hold harmless HHSC from and against any losses, costs or expenses resulting from any inaccurate or incomplete information contained in the response. The response constitutes an irrevocable proposal by CONTRACTOR to implement the proposed changes on the terms set forth in the response.

(iv) If CONTRACTOR desires to propose a change, it must deliver a change request to HHSC that includes the information described in Section 1.18(a)(2), above.

(v) If HHSC accepts CONTRACTOR's proposal or change request, the Parties will draft and 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.

(vi) The implementation of certain amendments, modifications, and changes to the Agreement may be subject to the approval of the Centers for Medicare and Medicaid Services ("CMS").

Section 1.19 Termination by Contractor

(a) *Failure to Pay*

CONTRACTOR may terminate this Agreement if HHSC fails to pay CONTRACTOR undisputed charges when due as required under this Agreement. Retaining premium, recoupment, sanctions, withholding, setoff or penalties that are allowed under this Agreement or that result from the CONTRACTOR's failure to perform or the CONTRACTOR's default under the terms of this Agreement is not cause for termination. Termination for failure to pay does not release HHSC from the obligation to pay undisputed charges for services provided prior to the termination date.

If HHSC fails to pay undisputed charges when due, then the CONTRACTOR may submit a notice of intent to terminate for failure to pay in accordance with the requirements of Subsection 1.20(b). If HHSC pays all undisputed amounts then due within thirty (30) days after receiving the notice of intent to terminate, the CONTRACTOR cannot proceed with termination of the Agreement under this Section.

(b) *Notice of Intent to Terminate*

In order to terminate the Agreement pursuant to this Section, CONTRACTOR must give HHSC at least 120 days written notice of intent to terminate. The termination date will be calculated as the last day of the month following one hundred and twenty (120) days from the date the notice of intent to terminate is received by HHSC.

Section 1.20 Authority to Execute

The Parties have executed this contract in their capacities as stated below with authority to bind their organizations on the dates set forth by their signatures.

HEALTH & HUMAN SERVICES COMMISSION

Charles Smith

Title: Executive Commissioner

Date: 8-31-2017

LOGISTICARE SOLUTIONS, LLC

Albert Cortina

Title: Chief Administrative Officer

Date: August 11, 2017

Exhibit A

HHSC's Uniform Terms and Conditions (UTC), version 1.5; specifically including the following Special Terms and Conditions of Article 16:

16.01
16.02
16.04
16.05
16.08

UTC Sections 9.03 and 15.02 do not apply to this Agreement.

HHSC Uniform Terms
and Conditions Versio

Health and Human Services Commission

HHSC Uniform Terms and Conditions
Version 1.5

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.5 MTO	5/21/14	Revised language specific to MTOs

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.
[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

CONTENTS

Article 1. Introduction

Section 1.01 Inducements.

In making the award of the Agreement, the Health and Human Services Commission (HHSC) relies on CONTRACTOR's assurances of the following:

(1) CONTRACTOR and its subcontractors are established providers of the types of services described in the RFP;

(2) CONTRACTOR and its subcontractors have the skills, qualifications, expertise, financial resources, and experience necessary to perform the services described in the RFP, CONTRACTOR's Proposal, and the 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 RFP, has timely raised all questions or objections to the RFP, 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;

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

Accordingly, on the basis of the terms and conditions of the Agreement, HHSC desires to engage CONTRACTOR to perform the services described in the Agreement under the terms and conditions set forth in the Agreement.

Section 1.02 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 or include 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 expressly agree in writing will survive the termination or expiration; or

(2) Remain to be performed or by their nature would be intended or are explicitly 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 to 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.

Section 1.03 No implied 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. CONTRACTOR may not rely upon implied authority and 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.

Section 1.04 Legal Authority.

(a) HHSC is authorized to enter into the Agreement under Chapter 531 or 533, Texas Government Code; Section 2155.144, Texas Government Code; or Chapter 62, Texas Health & Safety Code. CONTRACTOR is authorized to enter into the Agreement pursuant to the authorization of its governing board or controlling owner or officer.

(b) 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.

Article 2. Definitions

As used in the Agreement, the following terms and conditions have the meanings assigned below:

"Agreement" means the formal, written, and legally enforceable agreement and amendments between the Parties.

"Change" means any alteration, adjustment, exchange, substitution, or modification of the Services under the Agreement that are authorized in accordance with Article 7 of the Agreement.

"Change Order Request" means a request to make a change in the Services or Deliverables under the Agreement.

"Children's Health Insurance Program" or **"CHIP"** means the health insurance program authorized and funded pursuant to Title XXI, Social Security Act (42 U.S.C. §§ 1397aa-1397jj) and administered by HHSC.

"Confidential Information" means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) that consists of:

(1) Confidential Client information, including Protected Health Information;

(2) All non-public budget, expense, payment and other financial information;

(3) All Privileged Work Product;

(4) All information designated by HHSC or any other state agency as confidential, including all information designated as confidential under the Texas Public Information Act, Texas Government Code, Chapter 552;

(5) Unless publicly disclosed by HHSC or the state, the pricing, payments, and terms and conditions of the Agreement;

(6) Information that is utilized, developed, received, or maintained by HHSC, the CONTRACTOR, or participating state agencies for the purpose of fulfilling a duty or obligation under the Agreement and that has not been publicly disclosed; and

(7) Information designated as Confidential in HHSC's Data Use Agreement if incorporated as part of the Agreement. In the event of conflict the provisions and definition of Confidential in HHSC's Data Use Agreement will control.

"Corrective Action Plan" means the detailed written plan required by HHSC to correct or resolve a deficiency in performance or breach of the Agreement.

"Deliverable" means a work product prepared, developed, or procured by CONTRACTOR as part of the Services under the Agreement for the use or benefit of HHSC or the State of Texas.

"Disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual.

"Effective Date" means the date of complete execution of the Agreement or another date agreed to by the Parties. For purposes of the Agreement, the term includes any period under which work is performed in accordance with a properly executed Letter of Intent between HHSC and CONTRACTOR.

"Force majeure event" means any failure or delay in performance of a duty by a Party under the Agreement that is caused by fire, flood, hurricane, tornadoes, earthquake, an act of God, an act of war, riot, civil disorder, or any similar event beyond the reasonable control of such Party and without the fault or negligence of such Party.

"Health and Human Services Commission" or **"HHSC"** means the administrative agency within the executive department of Texas state government established under Chapter 531, Texas Government Code or its designee, including, but not limited to, the Texas Health and Human Services Agencies.

"HHSC Programs" means the public health and human service programs administered by HHSC, including but not limited to Medicaid and CHIP.

"Initial Term" means the period between the Effective Date and the original expiration date of the Agreement.

"Material Subcontract" means any Subcontract that exceeds, or is reasonably expected to exceed, $100,000 per year. Any Subcontracts between the CONTRACTOR and a single entity that are split into separate agreements by time period, Program, or

Service Area, etc., may be consolidated for the purpose of this definition.

"Material Subcontractor (or Major Subcontractor)" means any entity with a Material Subcontract with CONTRACTOR.

"Medicaid" means the medical assistance entitlement program authorized and funded pursuant to Title XIX, Social Security Act (42 U.S.C. § 1396 *et seq*.) and administered by HHSC.

"Parties" means HHSC and CONTRACTOR, collectively.

"Party" means either HHSC or CONTRACTOR, individually.

"Proposal" means the proposal submitted by the CONTRACTOR in response to the RFP.

"Public information" means information that:

(1) Is collected, assembled, or maintained under a law or ordinance or in connection with the transaction of official business by a governmental body or for a governmental body;

(2) The governmental body owns or has a right of access to; and

(3) Is not Confidential Information.

"Request for Proposals" or **"RFP"** means the procurement solicitation instrument issued by HHSC and any addendums under which the Agreement was awarded and is executed.

"Scope of Work" means the description of Services and Deliverables specified in the Agreement, the RFP, and any agreed modifications .

"Services" means the tasks, functions, and responsibilities assigned and delegated to CONTRACTOR under the Agreement.

"Software" means all operating system and applications software used or created by CONTRACTOR to provide the Services under the Agreement.

"Subcontract" means any written agreement between CONTRACTOR and other party to fulfill the requirements of the Agreement. All subcontracts are required to be in writing.

"Subcontractor" means any individual or entity that has entered into a subcontract with CONTRACTOR.

"Turnover Plan" means the written plan approved by HHSC, and to be employed in the event that the work described in the Agreement transfers to another vendor from CONTRACTOR. HHSC may require CONTRACTOR to develop a Turnover Plan at any time during the term of the Agreement at HHSC's discretion. The Turnover Plan describes CONTRACTOR's policies and procedures that will assure:

(1) The least disruption in the delivery of services during the transition to a substitute vendor; and

(2) Cooperation with HHSC and the substitute vendor in transferring information and services to a substitute vendor.

Article 3. General Terms and Conditions

Section 3.01 Agreement elements.

(a) *Agreement documentation.*

The agreement between the Parties will consist of the Managed Transportation Organization Agreement executed by the Parties, Exhibits, or Attachments to that document, these Uniform Terms and Conditions, the RFP (and CONTRACTOR's Proposal and any agreed to modifications (incorporated by reference).

(b) *Order of documents.*

Unless otherwise agreed, in the event of any conflict or contradiction between or among these documents, the documents will control in the following order of precedence:

(1) The final executed document that bears the signature of the Parties, and all amendments to that document;

(2) The RFP;

(3) these Uniform Terms and Conditions

(3) CONTRACTOR's Proposal and any agreed to modifications.

Section 3.02 Funding.

The Agreement is conditioned on the availability of state and federal appropriated funds. 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, or 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 Article 11 (Remedies and Disputes) 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 that represent accepted Services or Deliverables that are pending at the time funds become unavailable. HHSC will make best efforts to provide reasonable written advance notice to CONTRACTOR upon learning that funding for the Agreement may be discontinued.

Section 3.03 Delegation of authority.

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 3.04 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 of any immunities from suit or from liability that HHSC or the State of Texas may have by operation of law.

Section 3.05 Force majeure.

Neither Party will 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, 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 or otherwise waive this right as a defense.

Section 3.06 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 3.07 Most favored customer.

The CONTRACTOR agrees that if during the term of the Agreement, the CONTRACTOR enters into any agreement with any other governmental customer, or any non-affiliated commercial customer by which it agrees to provide equivalent services at lower prices, or additional services at comparable prices, the Agreement will, at HHSC's option, be amended to accord equivalent advantage to HHSC.

Section 3.08 Publicity.

(a) Except as provided in the paragraphs below, 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 media release, public announcement, or public disclosure relating to the Agreement or its subject matter, including 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).

(b) CONTRACTOR may publish, at its sole expense, results of CONTRACTOR performance under the Agreement with HHSC's prior review and approval, which HHSC may exercise at its sole discretion. Any publication (written, visual, or sound) will acknowledge the support received from HHSC and any Federal agency, as appropriate. CONTRACTOR will provide HHSC at least three (3) copies of any such publication prior to public release. CONTRACTOR will provide additional copies at the request of HHSC.

(c) CONTRACTOR may include information concerning the Agreement's terms, subject matter, and estimated value in any report to a governmental body to which the CONTRACTOR is required by law to report such information.

Section 3.09 Assignment.

(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. 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 obligations under the Agreement.

(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 (an "Assignee") 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, its obligation for all or any portion of the purchase payments, in whole or in part.

Section 3.10 Cooperation with other vendors and prospective vendors.

(a) HHSC may award supplemental contracts for work related to the Agreement, or any portion thereof. HHSC reserves the right to award the contract as a joint venture between two or more potential vendors, if such an arrangement is in the best interest of HHSC. CONTRACTOR agrees to cooperate with such other vendors, and will not commit or permit any act that may interfere with the performance of work by any other vendor.

(b) CONTRACTOR agrees that when HHSC so requests, CONTRACTOR will allow parties interested

in bidding for HHSC contracts, during the competitive procurement, to have reasonable access during normal business hours to software, systems documentation, and site visits to the CONTRACTOR's facilities. 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 competitive procurement.

Section 3.11 Renegotiation and reprocurement rights.

(a) *Renegotiation of Agreement terms.*

Notwithstanding anything in the Agreement to the contrary, HHSC may at any time during the term of the Agreement exercise the option to notify CONTRACTOR that HHSC has elected to renegotiate certain terms of the Agreement. Upon CONTRACTOR's receipt of any notice under this Section, CONTRACTOR and HHSC will undertake good faith negotiations of the subject terms of the Agreement.

(b) *Reprocurement of the services or procurement of additional services.*

Notwithstanding anything in the Agreement to the contrary, whether or not HHSC has accepted or rejected CONTRACTOR's Services or Deliverables provided during any period of the Agreement, HHSC may at any time issue requests for proposals or offers to other potential contractors for performance of any portion of the Services covered by the Agreement or services similar or comparable to the Services performed by CONTRACTOR under the Agreement.

(c) *Termination rights upon reprocurement.*

If HHSC elects to procure the Services or any portion of the Services from another vendor in accordance with this Section, HHSC will have the termination rights set forth in Article 11 of the Agreement.

Section 3.12 RFP errors and omissions.

CONTRACTOR will not take advantage of any errors or omissions in the RFP or the Agreement. CONTRACTOR must promptly notify HHSC of any errors or omissions that are discovered. Failure to notify HHSC of any errors will constitute a waiver of those errors.

Section 3.13 Attorneys' fees.

In the event of any litigation, appeal, or other legal action to enforce any provision of the Agreement, CONTRACTOR agrees to pay all expenses of such action, including attorneys' fees and costs if HHSC is the prevailing or substantially prevailing Party.

Section 3.14 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 3.15 Ensuring timely performance.

The Parties acknowledge the need to ensure uninterrupted and continuous performance of the Scope of Work under the Contract, therefore, HHSC may terminate this Contract or apply any other remedy as noted in Article 11 (Remedies and Disputes) if CONTRACTOR's performance is not timely.

Article 4. Contractor Personnel Management

Section 4.01 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.

Section 4.02 Responsibility for CONTRACTOR personnel.

(a) 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.

(b) 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.

(c) 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.

(d) CONTRACTOR assumes sole and full responsibility for its acts and omissions and the acts and omissions of its personnel and subcontractors.

(e) 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, 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).

Section 4.03 Cooperation with HHSC and state administrative agencies.

(a) *Cooperation with HHSC contractors.*

CONTRACTOR agrees to reasonably cooperate with and work with the state's contractors, subcontractors and third-party representatives as requested by HHSC. To the extent permitted by HHSC's financial and personnel resources, HHSC agrees to reasonably cooperate with CONTRACTOR and to use its best efforts to ensure that HHSC's other HHSC Programs contractors reasonably cooperate with CONTRACTOR.

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

CONTRACTOR must ensure that CONTRACTOR personnel will cooperate with HHSC or other state or federal administrative agency personnel at no charge to HHSC for purposes relating to the administration of HHSC programs including, but not limited to the following purposes:

(1) The investigation and prosecution of fraud, abuse, and waste in the HHSC programs;

(2) Audit, inspection, or other investigative purposes; and

(3) Testimony in judicial or quasi-judicial proceedings relating to the Services under the Agreement or other delivery of information to HHSC or other agencies' investigators or legal staff.

Section 4.04 Conduct of and responsibility for CONTRACTOR personnel.

(a) While performing the Services or Deliverables, CONTRACTOR's personnel and subcontractors must:

(1) Comply with applicable Agreement terms, state and federal rules, regulations, HHSC's policies, and HHSC's requests regarding personal and professional conduct; and

(2) Otherwise conduct themselves in a businesslike and professional manner.

(b) 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.

(c) 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.

(d) 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.

(e) CONTRACTOR agrees to be responsible for the following in 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*.).

Section 4.05 Responsibility for subcontractors.

(a) 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.

(b) 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.

(c) CONTRACTOR must identify any subcontractor that is a newly-formed subsidiary or entity, whether or not an affiliate of CONTRACTOR, substantiate the proposed subcontractor's ability to perform the subcontracted Services, and certify to HHSC that no loss of service will occur as a result of the performance of such subcontractor. The 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.

(d) At least 30 days prior to executing a Material Subcontract or other agreement with a third party with a value greater than $100,000.00, CONTRACTOR must submit a copy of the agreement to HHSC for HHSC's review at HHSC's option. HHSC reserves the right 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.

Section 4.06 HHSC's ability to contract with subcontractors.

The 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.

Article 5. Governing Law and Regulations

Section 5.01 Governing law and venue.

The 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 11.11, Dispute Resolution, proper venue for a claim arising from the Agreement will be in a court of competent jurisdiction in Travis County, Texas.

Section 5.02 CONTRACTOR responsibility for compliance with laws and regulations.

(a) CONTRACTOR is responsible for compliance with 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.

(b) CONTRACTOR is responsible for ensuring each of its employees, agents, or subcontractors who provide Services or Deliverables under the Agreement are properly licensed, certified, or have proper permits to perform any activity related to the Services.

(c) CONTRACTOR warrants that the Services and Deliverables comply with all applicable federal, state, and county laws, regulations, codes, ordinances, guidelines, and policies. CONTRACTOR will indemnify and hold harmless HHSC from and against any losses, liability, claims, damages, penalties, costs, fees, or expenses arising from or in connection with CONTRACTOR's failure to comply with or violation of any such law, regulation, code, ordinance, or policy.

Section 5.03 Compliance with immigration laws.

CONTRACTOR must comply with the requirements of the Immigration and Nationality Act (8 U.S.C § 1101 et seq.) and all subsequent immigration laws and amendments.

Section 5.04 Compliance with anti-discrimination laws.

(a) CONTRACTOR must comply with state and federal anti-discrimination laws, including:

(1) Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*);

(2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794);

(3) Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 *et seq*.);

(4) Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-6107);

(5) Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681-1688);

(6) Food Stamp Act of 1977 (7 U.S.C. § 200 *et seq*.); and

(7) HHSC's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to the Agreement.

CONTRACTOR must comply with all amendments to the above-referenced laws, and all requirements imposed by the regulations issued under these laws. These laws provide in part that no persons in the United States may, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion, be excluded from participation in or denied any aid, care, service or other benefits provided by Federal or State funding, or otherwise be subjected to discrimination.

(b) CONTRACTOR must comply with Title VI of the Civil Rights Act of 1964, and its implementing regulations at 45 C.F.R. Part 80 or 7 C.F.R. Part 15,

prohibiting a contractor from adopting and implementing policies and procedures that exclude or have the effect of excluding or limiting the participation of clients in its programs, benefits, or activities on the basis of national origin. Applicable state and federal civil rights laws require contractors to provide alternative methods for ensuring access to services for applicants and recipients who cannot express themselves fluently in English. CONTRACTOR must ensure that its policies do not have the effect of excluding or limiting the participation of persons in its programs, benefits, and activities on the basis of national origin. CONTRACTOR also must take reasonable steps to provide services and information, both orally and in writing, in appropriate languages other than English, in order to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits, and activities.

(c) CONTRACTOR must comply with Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16. These provide in part that any organization that participates in programs funded by direct financial assistance from the United States Department of Agriculture or the United States Department of Health and Human Services will not, in providing services, discriminate against a program beneficiary or prospective program beneficiary on the basis of religion or religious belief.

(d) Upon request, CONTRACTOR will provide HHSC with copies of all of the CONTRACTOR'S civil rights policies and procedures.

(e) CONTRACTOR must 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 calendar days after receipt of a complaint. Notice provided under 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.

Section 5.05 Compliance with environmental protection laws.

CONTRACTOR must comply with state and federal environmental laws, including without limitation::

(a) *Pro-Children Act of 1994.*

CONTRACTOR must comply with the Pro-Children Act of 1994 (20 U.S.C. § 6081 *et seq.*), as applicable, regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products.

(b) *National Environmental Policy Act of 1969.*

CONTRACTOR must comply with any applicable provisions relating to the institution of environmental quality control measures contained in the National Environmental Policy Act of 1969 (42 U.S.C. § 4321 *et seq.*) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality").

(c) *Clean Air Act and Water Pollution Control Act regulations.*

CONTRACTOR must comply with any applicable provisions relating to required notification of facilities violating the requirements of Executive Order 11738 ("Providing for Administration of the Clean Air Act and the Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, or Loans").

(d) *State Clean Air Implementation Plan.*

CONTRACTOR must comply with any applicable provisions requiring conformity of federal actions to State (Clean Air) Implementation Plans under §176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. § 740 *et seq.*).

(e) *Safe Drinking Water Act of 1974.*

CONTRACTOR must comply with applicable provisions relating to the protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (21 U.S.C. § 349; 42 U.S.C. §§ 300f to 300j-9).

Section 5.06 Compliance with Fraud, Waste, and Abuse requirements.

CONTRACTOR, CONTRACTOR's personnel, and all subcontractors must comply with all fraud, waste, and abuse requirements found in *HHS Circular C-027*. (http://www.hhsc.state.tx.us/news/circulars/C-027.shtml) If CONTRACTOR, CONTRACTOR's personnel, or Subcontractors suspect fraud, waste, or abuse (including employee misconduct that would constitute fraud, waste, or abuse), CONTRACTOR, CONTRACTOR's personnel, or Subcontractors must immediately report the questionable activity to both the Office of Inspector General (HHSC-OIG) and the State Auditor's Office (SAO).

Section 5.07 Technology Access.

All technological solutions offered by the CONTRACTOR must comply with the requirements of Texas Government Code § 531.0162. This includes providing technological solutions that meet federal accessibility standards for persons with disabilities, as applicable.

Section 5.08 Electronic and Information Resources Accessibility Standards.

(a) Applicability.

The following Electronic and Information Resources (EIR) requirements apply to the Contract because the CONTRACTOR performs services that include EIR that: (i) HHSC employees are required or permitted to access; or (ii) members of the public are required or permitted to access. This Section does

not apply to incidental uses of EIR in the performance of a Contract, 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 Contract. 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.

(b) Definitions.

For purposes of this Section:

"Accessibility Standards" means the Electronic and Information Resources Accessibility Standards and the Web Site Accessibility Standards/Specifications.

"**Electronic and Information Resources**" means information resources, including information resources technologies, and any equipment or interconnected system of equipment that is used in the creation, conversion, duplication, or delivery of data or information. The term includes telephones and other telecommunications products, information kiosks, transaction machines, Internet websites, multimedia resources, and office equipment, including copy machines and fax machines.

"Electronic and Information Resources Accessibility Standards" means the accessibility standards for electronic and information resources contained in Volume 1 Tex.Admin. Code Chapter 213.

"Web Site Accessibility Standards/ Specifications" means standards contained in Volume 1 Tex. Admin. Code Chapter 206.

"Product" means information resources technology that is, or is related to, EIR.

(c) Accessibility Requirements.

Under Tex. Gov't Code Chapter 2054, Subchapter M, and implementing rules of the Texas Department of Information Resources, HHSC must procure Products that comply with the Accessibility Standards when those Products are available in the commercial marketplace or when those Products are developed in response to a procurement solicitation. Accordingly, CONTRACTOR must provide electronic and information resources and associated Product documentation and technical support that comply with the Accessibility Standards.

(d) Evaluation, Testing, and Monitoring.

(1) HHSC may review, test, evaluate and monitor CONTRACTOR's Products and associated documentation and technical support for compliance with the Accessibility Standards. Review, testing, evaluation and monitoring may be conducted before and after the award of a contract. Testing and monitoring may include user acceptance testing.

Neither (1) the review, testing (including acceptance testing), evaluation or monitoring of any Product, nor (2) the absence of review, testing, evaluation or monitoring, will result in a waiver of the State's right to contest the CONTRACTOR's assertion of compliance with the Accessibility Standards.

(2) CONTRACTOR agrees to cooperate fully and provide HHSC and its representatives timely access to Products, records, and other items and information needed to conduct such review, evaluation, testing, and monitoring.

(e) Representations and Warranties.

(1) CONTRACTOR represents and warrants that: (i) as of the Effective Date of the Agreement, the Products and associated documentation and technical support comply with the Accessibility Standards as they exist at the time of entering the Contract, unless and to the extent the Parties otherwise expressly agree in writing; and (ii) if the Products will be in the custody of the state or an HHS Agency's client or recipient after the Contract expiration or termination, the Products will continue to comply with Accessibility Standards after the expiration or termination of the Contract Term, unless HHSC or its clients or recipients, as applicable, use the Products in a manner that renders it noncompliant.

(2) In the event CONTRACTOR should have known, becomes aware, or is notified that the Product and associated documentation and technical support do not comply with the Accessibility Standards, CONTRACTOR represents and warrants that it will, in a timely manner and at no cost to HHSC, perform all necessary steps to satisfy the Accessibility Standards, including remediation, replacement, and upgrading of the Product, or providing a suitable substitute.

(3) CONTRACTOR acknowledges and agrees that these representations and warranties are essential inducements on which HHSC relies in awarding this Contract.

(4) CONTRACTOR's representations and warranties under this subsection will survive the termination or expiration of the Contract and will remain in full force and effect throughout the useful life of the Product.

(f) Remedies.

(1) Under Tex. Gov't Code § 2054.465, neither CONTRACTOR nor any other person has cause of action against HHSC for a claim of a failure to comply with Tex. Gov't Code Chapter 2054, Subchapter M, and rules of the Department of Information Resources.

(2) In the event of a breach of CONTRACTOR's representations and warranties,

CONTRACTOR will be liable for direct, consequential, indirect, special, or liquidated damages and any other remedies to which HHSC may be entitled under this Contract and other applicable law. This remedy is cumulative of any other remedies to which HHSC may be entitled under this Contract and other applicable law.

Section 5.09 Prohibition Against Performance Outside the United States.

(aHHSC is responsible for administering several public programs that require the collection and maintenance of information relating to persons who apply for and receive services from HHSC programs. This information consists of, among other things, personal financial and medical information and information designated "Confidential Information" under state and federal law and the Agreement. Some of this information may, within the limits of the law and the Agreement, be shared from time to time with CONTRACTOR or a Subcontractor for purposes of performing the Services or providing the Deliverables under the Agreement.

(B) HHSC is legally responsible for maintaining the confidentiality and integrity of information relating to applicants and recipients of HHSC services and ensuring that any person or entity that receives this information—including CONTRACTOR and any Subcontractor—is similarly bound by these obligations.

(C) HHSC also is responsible for the development and implementation of computer software and hardware to support HHSC programs. These items are paid for, in whole or in part, with state and federal funds. The federal agencies that fund these items maintain a limited interest in the developed or acquired software and hardware.

(D) Some of the software used or developed by HHSC may also be subject to statutory restrictions on the export of technology to foreign nations, including the Export Administration Regulations, 15 C.F.R. Parts 730-774.

(2) In view of these obligations, and to ensure accountability, integrity, and the security of the information maintained by or for HHSC and the work performed on behalf of HHSC, HHSC determines that it is necessary and appropriate to require that:

(A) All work performed under the Agreement must be performed exclusively within the United States; and

(B) All information obtained by CONTRACTOR or a Subcontractor under the Agreement must be maintained within the United States.

(3) Further, HHSC finds it necessary and appropriate to forbid the performance of any work or the maintenance of any information relating or obtained under the Agreement to occur outside of the United States except as authorized or approved by HHSC in writing.

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

(1) As used in this Section 5.08, the term "within the United States" means any location inside the territorial boundaries comprising the United States of America, including any of the 48 contiguous states, 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 United States of America, including any of the 48 contiguous states, the states of Alaska and Hawaii, and the District of Columbia.

(c) 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 of the United States.

(d) Performance of Work under Agreement.

(1) Unless otherwise approved in advance by HHSC in writing, and subject to the exceptions specified in paragraph (e) of this Section 5.08, CONTRACTOR and all Subcontractors, vendors, agents, and service providers of or for CONTRACTOR must perform all services under the Agreement, including all tasks, functions, and responsibilities assigned and delegated to CONTRACTOR under the Agreement, within the United States.

(A) This obligation includes all Services, including information technology services, processing, transmission, storage, archiving, data center services, disaster recovery sites and services, customer support), medical, dental, laboratory, and clinical services.

(B) All custom software prepared for performance of the Agreement, and all

modifications of custom, third party, or vendor proprietary software, must be performed within the United States.

(2) Unless otherwise approved in advance by HHSC in writing, and subject to the exceptions specified in paragraph (e) of this Section 5.08, CONTRACTOR and all subcontractors, vendors, agents, and service providers of or for CONTRACTOR must not permit any person to perform work under the Agreement from a location outside the United States.

(e) Exceptions.

(1) COTS Software. The foregoing requirements will not preclude the acquisition or use of commercial off-the-shelf software (COTS) that is developed outside the United States or hardware that is generically configured outside the United States.

(2) Foreign-made Products and Supplies. The foregoing requirements will not preclude CONTRACTOR from acquiring, using, or reimbursing products or supplies that are manufactured outside the United States, provided such products or supplies are commercially available within the United States for acquisition or reimbursement by HHSC.

(3) HHSC Prior Approval. The foregoing requirements will not preclude CONTRACTOR from performing work outside the United States that HHSC has approved in writing and that HHSC has confirmed will not involve the sharing of Confidential Information outside the United States.

(f) Disclosure.

CONTRACTOR must disclose all Services and Deliverables under or related to the Agreement that CONTRACTOR intends to perform or has performed outside the United States, whether directly or via Subcontractors, vendors, agents, or service providers.

(g) Remedy.

(1) CONTRACTOR's violation of this Section 5.09 will constitute a material breach in accordance with Article 11. CONTRACTOR will be liable to HHSC for all monetary damages, in the form of actual, consequential, direct, indirect, special, or liquidated damages in accordance with the Agreement.

(2) HHSC may also terminate the Agreement becuase the CONTRACTOR's violatation Section 5.09 constitutes a material breach. HHSC will give the CONTRACTOR notice of at least one calendar day before the effective date of the termination.

Article 6. Service Levels and Performance Measurement

Section 6.01 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 in its Proposal and as revised by CONTRACTOR and finally approved by HHSC;

(c) Delivery of the Services and Deliverables in accordance with the service levels and availability proposed in its Proposal and as finally approved or accepted by HHSC;

(d) Results of audits performed by HHSC or its representatives in accordance with Article 8;

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

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

Article 7. Amendments, Modifications, and Change Order Requests

Section 7.01 Amendments and modifications.

(a) *Amendments and modifications resulting from changes in law or contract.*

The Agreement may be amended by mutual written agreement of the Parties if changes in federal or state laws, rules, regulations, policies, guidelines or circumstances affect the performance of the work. The Parties will develop a business plan for negotiating appropriate change order and amendment procedures.

(b) *Modifications resulting from imposition of remedies.*

The Agreement may be modified under the terms of Article 11 (relating to Remedies and Disputes).

Section 7.02 Required compliance with amendment modification procedures.

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 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 HHSC.

Article 8. Audit and Financial Compliance

Section 8.01 Record retention and audit.

CONTRACTOR must maintain, and require its subcontractors to maintain, supporting information and documents that are adequate to ensure that payments are made and paid in accordance with applicable federal and state requirements, and are sufficient to ensure the accuracy and validity of CONTRACTOR invoices. Thesedocuments, including all original claims forms, will be maintained and retained by CONTRACTOR or its subcontractors for a period of seven years after the date of submission of the final billing 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.

Section 8.02 Access to records, books, and documents.

(a) Upon reasonable notice, CONTRACTOR must provide, and cause its subcontractors to provide, the officials and entities identified in this Section with prompt, reasonable, and adequate access to any records, books, documents, and papers that are directly pertinent to the performance of the Agreement.

(b) CONTRACTOR and its subcontractors must provide the access described in this Section upon HHSC's request. This request may include the following purposes:

(1) Examination;

(2) Audit;

(3) Investigation;

(4) Contract administration; or

(5) The making of copies, excerpts, or transcripts.

(c) The access required must be provided to the following officials or entities:

(1) The United States Department of Health and Human Services or its designee;

(2) The Comptroller General of the United States or its designee;

(3) Medicaid program personnel from HHSC or its designee;

(4) The Office of Investigations and Enforcement of HHSC;

(5) Any independent verification and validation contractor or quality assurance contractor, when acting on behalf of HHSC;

(6) The Office of the State Auditor of Texas or its designee;

(7) A state or federal law enforcement agency;

(8) A special or general investigating committee of the Texas Legislature or its designee; and

(9) Any other entity identified by HHSC.

(d) 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.

(e) Upon request, CONTRACTOR must provide copies of the information described in this Section free of charge to HHSC and the entities described in subsection (c).

Section 8.03 Audits and inspections of Services and Deliverables.

(a) Upon notice from HHSC, CONTRACTOR will provide, and will cause its subcontractors to provide, such auditors and inspectors as HHSC may from time to time designate, with access to:

(1) CONTRACTOR service locations, facilities, or installations;

(2) CONTRACTOR Software and Equipment; and

(3) CONTRACTOR records.

(b) CONTRACTOR must provide as part of the Services any assistance that such auditors and inspectors reasonably may require to complete such audits or inspections.

Section 8.04 Response/compliance with audit or inspection findings.

(a) 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 the Services and Deliverables or any other deficiency contained in any audit, review, or inspection conducted under the 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).

(b) CONTRACTOR must bear the expense of compliance with any finding of noncompliance under the Agreement that is:

(1) Required by a Texas or Federal law, regulation, rule or other audit requirement relating to CONTRACTOR's business;

(2) Performed by CONTRACTOR as part of the Services and Deliverables; or

(3) Necessary due to CONTRACTOR's noncompliance with any law, regulation, rule or audit requirement imposed on CONTRACTOR.

(c) As part of the Services, CONTRACTOR must provide to HHSC upon request a copy of those portions of CONTRACTOR's and its subcontractors' internal audit reports relating to the Services and Deliverables provided to the state under the Agreement.

Section 8.05 Audit of CONTRACTOR fees & costs.

(a) CONTRACTOR will provide, and will cause its subcontractors to provide, to HHSC and its designees access to such financial records and supporting documentation reasonably requested by HHSC.

(b) In addition to the normal monthly review and payment of administrative vouchers, HHSC may audit the Fees charged to HHSC to determine that such Fees are accurate and in accordance with the Agreement.

(c) If, as a result of such audit, HHSC determines that CONTRACTOR has included unallowable costs in its FSR, or has overcharged the state, HHSC will notify CONTRACTOR of the amount of such costs or overcharge and CONTRACTOR will promptly pay to HHSC the amount of the overcharge, plus interest. In the event of unallowable costs, the Experience Rebate will be revised according to the Contract. Interest on such overpayment amount will be calculated from the date of receipt by the CONTRACTOR of the overcharged amount until the date of payment to HHSC, and will be calculated at 12% per annum, compounded daily, but in no event to exceed the highest lawful rate of interest. CONTRACTOR will reimburse HHSC for the cost of such audit.

Section 8.06 SAO Audit.

The CONTRACTOR understands that acceptance of funds under this Contract acts as acceptance of the authority of the State Auditor's Office (SAO), or any successor agency, to conduct an investigation in connection with those funds. The CONTRACTOR further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested. The CONTRACTOR will ensure that this clause concerning the authority to audit funds received indirectly by subcontractors through CONTRACTOR and the requirement to cooperate is included in any subcontract it awards.

Article 9. Terms and Conditions of Payment

Section 9.01 Rights of set-off.

(a) *General right of 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.

(b) *Duty to make payments.*

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.

Section 9.02 Expenses.

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 agreed upon by HHSC. CONTRACTOR will be responsible for payment of all expenses related to salaries, benefits, employment taxes, and insurance for its Staff. In addition, the costs associated with transportation, delivery, and insurance for each Deliverable will be paid for by CONTRACTOR.

Section 9.03 Disputed fees.

If HHSC 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. 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 continue to be paid to CONTRACTOR.

Section 9.04 Liability for taxes.

HHSC is not responsible in any way for the payment of any federal, state or local taxes 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.

Section 9.05 Liability for employment-related charges and benefits.

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 9.06 No additional consideration.

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 relating to the CONTRACTOR'S performance of the Agreement will be paid for by the CONTRACTOR.

Section 9.07 No increase in charges.

CONTRACTOR will not increase Charges during the term of the Agreement, except as authorized in Article 7.

Article 10. Disclosure and Confidentiality of Information

Section 10.01 Confidentiality.

(a) CONTRACTOR and all subcontractors, consultants, or agents under the Agreement must treat all information that is obtained through performance of the Services under the Agreement, including, but not limited to, information relating to applicants or recipients of HHSC Programs as Confidential Information to the extent that such information is deemed confidential in the Agreement or as provided under law and regulations.

(b) CONTRACTOR is responsible for understanding the degree to which information obtained through performance of the Agreement is confidential under state and federal law, regulations, or administrative rules.

(c) CONTRACTOR and all subcontractors, consultants, or agents under the Agreement may not use any information obtained through performance of the Agreement in any manner except as is necessary to the proper discharge of obligations and securing of rights under the Agreement.

(d) CONTRACTOR must have a system in effect to protect all records, documents, or other information deemed confidential under the Agreement that are obtained or maintained in connection with the activities funded under the Agreement. Any disclosure or transfer of Confidential Information by CONTRACTOR, including information required by HHSC, will be in accordance with the Agreement. If the CONTRACTOR receives a request for information deemed confidential under the Agreement, the CONTRACTOR will immediately notify the state of the request, and will make reasonable efforts to protect the information from public disclosure until further instructed by HHSC.

(e) In addition to the requirements stated in this Section, CONTRACTOR must comply with any policy, rule, or reasonable requirement of HHSC that relates to the safeguarding or disclosure of information relating to HHSC Programs recipients, CONTRACTOR'S operations, or the CONTRACTOR performance of the Agreement.

(f) In the absence of an HHSC Data Use Agreement incorporated into the Agreement, on expiration of the Agreement, or termination of the Agreement for any reason, all Confidential Information of a Party disclosed to, and all copies made by the other Party, will be returned to the disclosing Party or, at the disclosing Party's option, erased or destroyed. The recipient of the Confidential Information must provide the disclosing Party certificates evidencing this erasure or destruction.

(g) The obligations in this Section do not restrict any disclosure by a Party under any applicable law, or by order of any court or government agency, provided that the disclosing Party must give prompt notice to the non-disclosing Party of such order.

(h) With the exception of confidential HHSC Program recipient or client information, Confidential Information of a Party will not be afforded the protection of the Agreement if this data was:

(1) Already known to the receiving Party without restrictions at the time of its disclosure by the furnishing Party;

(2) Independently developed by the receiving Party without reference to the furnishing Party's Confidential Information;

(3) Rightfully obtained by the other Party without restriction from a third party after its disclosure by the furnishing Party;

(4) Publicly available other than through the fault or negligence of the other Party; or

(5) Released without restriction to anyone.

(i) If a Data Use and Business Associate Agreement (DUA) is incorporated in the Contract Agreement, the provisions of that DUA as updated or amended, will take precedence over any conflicting conditions in these Uniform Terms and Conditions.

Section 10.02 Disclosure of HHSC's Confidential Information.

(a) CONTRACTOR will immediately report to HHSC any and all unauthorized disclosures or uses of HHSC's Confidential Information of which it or its subcontractor(s), consultant(s), or agent(s) is aware or has knowledge. CONTRACTOR acknowledges that any publication or disclosure of HHSC's Confidential Information to others may cause immediate and irreparable harm to HHSC and may

constitute a violation of State or federal laws. If CONTRACTOR, its subcontractor(s), consultant(s), or agent(s) should publish or disclose such Confidential Information to others without authorization, HHSC will immediately be entitled to injunctive relief or any other remedies to which it is entitled under law or equity without requiring a cure period as described in Article 11. HHSC will have the right to recover from CONTRACTOR all damages and liabilities caused by or arising from CONTRACTOR's, its subcontractors', consultants', or agents' failure to protect HHSC's Confidential Information. Contractor will defend with counsel approved by HHSC, indemnify and hold harmless HHSC from all damages, costs, liabilities, and expenses (including without limitation reasonable attorneys' fees and costs) caused by or arising from CONTRACTOR's or its subcontractors', consultants' or agents' failure to protect HHSC's Confidential Information.

(b) CONTRACTOR will require its subcontractor(s), consultant(s), and agent(s) to comply with the terms of this provision.

Section 10.03 Requests for public information.

(a) HHSC agrees that it will promptly notify CONTRACTOR of a request for disclosure of public information filed in accordance with the Texas Public Information Act, Texas Government Code Chapter 552, that consists of the CONTRACTOR'S Confidential Information, including information to which CONTRACTOR believes it has a proprietary or commercial interest. HHSC will deliver a copy of the request for public information to CONTRACTOR.

(b) With respect to any information that is the subject of a request for disclosure, CONTRACTOR is required to demonstrate to the Texas Office of Attorney General the specific reasons why the requested information is confidential or otherwise excepted from required public disclosure under law. CONTRACTOR will provide HHSC with copies of all such communications.

(c) CONTRACTOR must make information defined as public information not otherwise excepted from disclosure under the Texas Public Information Act, Texas Government Code Chapter 552, available to HHSC in a format agreeable to HHSC , accessible by the public, and at no additional charge to HHSC.

(d) To the extent authorized under the Texas Public Information Act, HHSC agrees to safeguard from disclosure information received from CONTRACTOR that the CONTRACTOR believes to be Confidential Information. CONTRACTOR must clearly mark such information as Confidential Information or provide written notice to HHSC that it considers the information confidential.

(e) To the extent allowed under the Texas Public Information Act, Texas Government Code Chapter 552, CONTRACTOR agrees that any consultant reports received by HHSC as result of the Services or Deliverables of the Agreement, may be distributed by HHSC, in its discretion, to any other state agency and the legislature. Any distribution may include posting on HHSC's website or the website of a standing committee of the legislature.

Section 10.04 Privileged Work Product.

(a) CONTRACTOR acknowledges that HHSC asserts that Privileged Work Product may be prepared in anticipation of litigation and that CONTRACTOR is performing the Services with respect of Privileged Work Product as an agent of HHSC, and that all matter related thereto is protected from disclosure by the Texas Rules of Civil Procedure, Texas Rules of Evidence, Federal Rules of Civil Procedure, or Federal Rules of Evidence.

(b) HHSC will notify CONTRACTOR of any Privileged Work Product to which CONTRACTOR has or may have access. After the CONTRACTOR is notified or otherwise becomes aware that such documents, data, database, or communications are Privileged Work Product, only CONTRACTOR personnel for whom such access is necessary for the purposes of providing the Services may have access to Privileged Work Product.

(c) If CONTRACTOR receives notice of any judicial or other proceeding seeking to obtain access to HHSC's Privileged Work Product, CONTRACTOR will:

(1) Immediately notify HHSC; and

(2) Use all reasonable efforts to resist providing such access.

(d) If CONTRACTOR resists disclosure of HHSC's Privileged Work Product in accordance with this Section, HHSC will, to the extent authorized under Civil Practices and Remedies Code or other applicable state law, have the right and duty to represent CONTRACTOR in such resistance or to retain counsel to so represent CONTRACTOR or to reimburse CONTRACTOR for reasonable attorneys' fees and expenses incurred in resisting such access.

(e) If a court of competent jurisdiction orders CONTRACTOR to produce documents, disclose data, or otherwise breach the confidentiality obligations imposed in the Agreement, or otherwise with respect to maintaining the confidentiality, proprietary nature, and secrecy of Privileged Work Product, CONTRACTOR will not be liable for breach of such obligation.

Section 10.05 Unauthorized acts.

Each Party agrees to:

(1) Notify the other Party promptly of any unauthorized possession, use, or knowledge, or attempt thereof, of any Confidential Information by any person or entity that may become known to it;

(2) Promptly furnish to the other Party full details of the unauthorized possession, use, or knowledge, or attempt thereof, and use reasonable efforts to assist the other Party in investigating or preventing the reoccurrence of any unauthorized possession, use, or

knowledge, or attempt thereof, of Confidential Information;

(3) Cooperate with the other Party in any litigation and investigation against third Parties deemed necessary by such Party to protect its proprietary rights; and

(4) Promptly prevent a reoccurrence of any such unauthorized possession, use, or knowledge of Confidential Information.

Section 10.06 Legal action.

Neither party may commence any legal action or proceeding in respect to any unauthorized possession, use, or knowledge, or attempt thereof, of Confidential Information by any person or entity, which action or proceeding identifies the other Party or its Confidential Information without such Party's consent.

Section 10.07 Information Security.

(a) CONTRACTOR and all subcontractors, consultants, or agents under the Agreement (collectively "CONTRACTOR") must comply with the following:

(1) Health and Human Services Enterprise Information Security Standards and Guidelines and
(2) Title 1, Sections 202.1 and 202.3 through 202.28, Texas Administrative Code.

(b) CONTRACTOR must comply with the following, as applicable:

(1) The Federal Information Security Management Act of 2002 (FISMA);
(2) The Health Insurance Portability and Accountability Act of 1996 (HIPAA);
(3) The Health Information Technology for Economic and Clinical Health Act (HITECH Act);
(4) Publication 1075 – Tax Information Security Guidelines for Federal, State and Local Agencies;
(5) National Institute of Standards and Technology (NIST) Special Publication 800-66 Revision 1 – An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security Rule;
(6) NIST Special Publication 800-53 Revision 3 – Recommended Security Controls for Federal Information Systems and Organizations; and
(7) NIST Special Publication 800-47 – Security Guide for Interconnecting Information Technology Systems.

(c) In addition to the requirements stated in this Section, CONTRACTOR must comply with any other state or federal law, regulation, or administrative rule relating to the specific HHSC program area that CONTRACTOR supports.

(d) Upon reasonable notice, CONTRACTOR must provide, and cause its subcontractors and agents to provide, HHSC or its designee, prompt, reasonable, and adequate access to any information security records, books, documents, and papers that are directly pertinent to the performance of the Agreement including:

(1) CONTRACTOR information security policies;
(2) CONTRACTOR information security procedures;
(3) CONTRACTOR information security standards;
(4) CONTRACTOR information security guidelines;
(5) CONTRACTOR security plan in compliance with NIST Special Publication 800-53 Revision 3;
(6) CONTRACTOR security violation reports;
(7) CONTRACTOR employee security acknowledgement agreements; and
(8) Lists of CONTRACTOR's employees with authorized access to HHSC confidential information.

Items (1) through (5) above are subject to HHSC's review and approval. Neither HHSC's review or approval, nor its fail to review or approve, will relieve, waive, or satisfy any of CONTRACTOR's obligations under the Agreement.

(e) CONTRACTOR will provide, and will cause its subcontractors and agents to provide, to HHSC periodic written certifications of compliance with controls and provisions relating to information security, including but not limited, those related to confidential data transfers and the handling and disposal of Protected Health Information (PHI), Electronic Protected Health Information (EPHI), and Personally Identifiable Information (PII). Acceptable forms of written compliance may be, but are not limited to:

(1) Statement on Standards for Attestation Engagements No. 16 (SSAE 16) Report;
(2) General Security Controls Audit;
(3) Application Controls Audit;
(4) Vulnerability Assessment; and
(5) Network/Systems Penetration Test.

(f) If a Data Use and Business Associate Agreement (DUA) is incorporated in the Contract Agreement, the provisions of that DUA as updated or amended, will take precedence over any conflicting conditions in these Uniform Terms and Conditions.

Article 11. Remedies and Disputes

Section 11.01 Understanding and expectations.

The remedies described in this Section are directed to CONTRACTOR's timely and responsive performance of the Services and Deliverables, and to the creation of a flexible and responsive relationship between the Parties.

Section 11.02 Tailored remedies.

(a) *Understanding of the Parties.*

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. 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.

(b) *Notice and opportunity to cure for non-material breach.*

(1) HHSC will notify CONTRACTOR in writing of specific areas of CONTRACTOR performance that fail to meet performance expectations, standards, or schedules, but that, in the determination of HHSC, do not result in a material deficiency or delay in the implementation or operation of the Services.

(2) CONTRACTOR will, within three business days (or another date approved by HHSC) of receipt of written notice of a non-material deficiency, provide HHSC a written response that:

(A) Explains the reasons for the deficiency, CONTRACTOR's plan to address or cure the deficiency, and the date and time by which the deficiency will be cured; or

(B) If CONTRACTOR disagrees with HHSC's findings, its reasons for disagreeing with HHSC's findings.

(3) CONTRACTOR's proposed cure of a non-material deficiency is subject to the approval of HHSC. CONTRACTOR's repeated commission of non-material deficiencies or repeated failure to resolve any such deficiencies may be regarded by HHSC as a material deficiency and entitle HHSC to pursue any other remedy provided in the Agreement or any other appropriate remedy HHSC may have at law or equity.

(c) *Corrective action plan.*

(1) At its option, HHSC may require CONTRACTOR to submit to HHSC a detailed written plan (the "Corrective Action Plan") to correct or resolve a material or non-matierial deficiency or breach of the Agreement.

(2) The Corrective Action Plan must provide:

(A) A detailed explanation of the reasons for the cited deficiency;

(B) CONTRACTOR's assessment or diagnosis of the cause;

(C) A specific proposal to cure or resolve the deficiency; and

(D) CONTRACTOR's timeline for cure or resolution of the deficiency

(3) The Corrective Action Plan must be submitted by the deadline set forth in HHSC's request for a Corrective Action Plan. The Corrective Action Plan is subject to approval by HHSC, which will not unreasonably be withheld.

(4) HHSC will notify CONTRACTOR in writing of HHSC's final disposition of HHSC's concerns. If HHSC accepts CONTRACTOR's proposed Corrective Action Plan, HHSC may:

(A) Condition such approval on completion of tasks in the order or priority that HHSC may prescribe;

(B) Disapprove portions of CONTRACTOR's proposed Corrective Action Plan; or

(C) Require additional or different corrective action(s).

(5) At any time during this process, HHSC reserves the right to:

(A) Suspend all, or part of, the Agreement, and to withhold further payment for the suspended portions of the Agreement; or

(B) Prohibit CONTRACTOR from incurring additional obligations of funds during investigation of the pending corrective action, if necessary, by CONTRACTOR or a decision by HHSC to terminate for cause.

(6) If HHSC rejects CONTRACTOR's written explanation or proposed Corrective Action Plan, HHSC may issue a Stop Work Order to CONTRACTOR or any of its subcontractors or suppliers. HHSC may delay the implementation of the Stop Work Order if it affects the completion of any of the Services in accordance with the approved Schedule or Work Plan.

(7) HHSC's acceptance of a Corrective Action Plan under this Section will not:

(A) Excuse CONTRACTOR's prior substandard performance;

(B) Relieve CONTRACTOR of its duty to comply with performance standards; or

(C) Prohibit HHSC from assessing additional tailored remedies or pursuing other appropriate remedies for continued substandard performance.

(d) *Administrative remedies.*

(1) At its discretion, HHSC may impose one or more of the following remedies for each item of noncompliance and will determine the scope and severity of the remedy on a case-by-case basis:

(A) Assess liquidated damages in accordance with the terms of the Agreement;

(B) Conduct accelerated monitoring of the CONTRACTOR. Accelerated monitoring includes more frequent or more extensive monitoring by HHSC or its agent;

(C) Require additional, more detailed, financial or programmatic reports to be submitted by CONTRACTOR;

(D) Decline to renew or extend the Agreement;

(E) Withhold or recoup payment ; or

(F) Terminate the Agreement in accordance with Section 11.03.

(2) For purposes of the Agreement, an item of noncompliance means a specific action of CONTRACTOR that:

(A) Violates a provision of the Agreement;

(B) Fails to meet an agreed measure of performance; or

(C) Represents a failure of CONTRACTOR to be reasonably responsive to a reasonable request of HHSC relating to the Services and Deliverables for information, assistance, or support within the timeframe specified by HHSC.

(3) HHSC will provide notice to CONTRACTOR of the imposition of an administrative remedy in accordance with this Section, with the exception of accelerated monitoring, which may be unannounced. HHSC may require CONTRACTOR to file a written response in accordance with this Section.

(4) The Parties agree that a state or federal statute, rule, regulation, or Federal guideline will prevail over the provisions of this Section unless the statute, rule, regulation, or guidelines can be read together with this Section to give effect to both.

(e) *Damages.*

(1) HHSC will be entitled to actual and consequential damages resulting from the CONTRACTOR'S failure to comply with any of the terms of the Agreement.

(2) In some cases, the actual damage to HHSC or the State of Texas as a result of CONTRACTOR'S failure to meet any aspect of the responsibilities of the Agreement or to meet specific performance standards set forth in the Agreement are difficult or impossible to determine with precise accuracy. Therefore, liquidated damages may be assessed in writing against and paid by the CONTRACTOR for failure to meet any aspect of the responsibilities of the Agreement or to meet the specific performance standards identified by the HHSC. Liquidated damages may be assessed if HHSC determines such failure is the fault of the CONTRACTOR (including the CONTRACTOR'S subcontractors or consultants) and is not materially caused or contributed to by HHSC or its agents. If at any time, HHSC determines the CONTRACTOR has not met any aspect of the responsibilities of the Agreement or the specific performance standards due to mitigating circumstances, HHSC reserves the right to waive all or part of the liquidated damages. All such waivers must be in writing, contain the reasons for the waiver, and be signed by the appropriate executive of HHSC.

(a) The liquidated damages prescribed in this Section are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of HHSC's projected financial loss and damage resulting from the CONTRACTOR's nonperformance, including financial loss as a result of project delays. Accordingly, in the event CONTRACTOR fails to perform in accordance with the Agreement, HHSC may assess liquidated damages as provided in this Section.

(3) If CONTRACTOR fails to perform any of the Services described in the Agreement, HHSC may assess liquidated damages for each occurrence of a liquidated damages event, to the extent consistent with HHSC's tailored approach to remedies and Texas law.

(4) HHSC may elect to collect liquidated damages:

(A) Through direct assessment and demand for payment delivered to CONTRACTOR; or

(B) By deduction of amounts assessed as liquidated damages as set-off against payments then due to CONTRACTOR for the Services or Deliverables or that become due at any time after assessment of the liquidated damages. HHSC will make deductions until the full amount payable by the CONTRACTOR is received by the state.

(f) *Equitable Remedies*

(1) 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.

(2) 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).

(g) *Suspension of Agreement*

(1) HHSC may suspend performance of all or any part of the Agreement if:

(A) HHSC determines that CONTRACTOR has committed a material breach of the Agreement;

(B) HHSC has reason to believe that CONTRACTOR has committed, assisted in the commission of, or failed to take appropriate action concerning fraud, abuse, malfeasance, misfeasance, or nonfeasance by any party concerning the Agreement; or

(C) HHSC determines that suspension of the Agreement in whole or in part is convenient or in the best interests of the State of Texas or the HHSC Programs.

(2) HHSC will notify CONTRACTOR in writing of its intention to suspend the Agreement in whole or in part. Such notice will:

(A) Be delivered in writing to CONTRACTOR;

(B) Include a concise description of the facts or matter leading to HHSC's decision; and

(C) Unless HHSC is suspending the contract for convenience, request a Corrective Action Plan from CONTRACTOR or describe actions that CONTRACTOR may take to avoid the contemplated suspension of the Agreement.

Section 11.03 Termination of Agreement.

In addition to other provisions of this article allowing termination, the Agreement will terminate upon the expiration date unless extended in accordance with the terms of the Agreement, or terminated sooner under the terms of the Agreement. Prior to completion of the Initial Term and any extensions or renewal thereof, all or a part of the Agreement may be terminated for any of the following reasons:

(a) *Termination by mutual agreement of the Parties.*

The Agreement may be terminated by mutual agreement of the Parties. Such agreement must be in writing.

(b) *Termination in the best interest of the state.*

HHSC may terminate the Agreement at any time when, in its sole discretion, HHSC determines that termination is in the best interests of HHSC. The termination will be effective on the date specified in HHSC's notice of termination.

(c) *Termination for cause.*

Except as otherwise provided by the U.S. Bankruptcy Code, or any successor law, HHSC may terminate the Agreementupon the following conditions:

(1) *Assignment for the benefit of all or substantially all of its creditors, appointment of receiver, or inability to pay debts*.

HHSC may terminate the Agreement if CONTRACTOR:

(A) Makes an assignment for the benefit of its creditors;

(B) Admits in writing its inability to pay its debts generally as they become due; or

(C) Consents to the appointment of a receiver, trustee, or liquidator of CONTRACTOR or of all or any part of its property.

(2) *Failure to adhere to laws, rules, ordinances, or orders.*

HHSC may terminate the Agreement if a court of competent jurisdiction finds CONTRACTOR failed to adhere to any laws, ordinances, rules, regulations or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of CONTRACTOR's duties under the Agreement.

(3) *Breach of confidentiality*.

HHSC may terminate the Agreement if CONTRACTOR breaches confidentiality obligations with respect to the Services and Deliverables provided under the Agreement.

(4) *Failure to maintain adequate personnel or resources.*

HHSC may terminate the Agreement if, after providing notice and an opportunity to correct, HHSC determines that CONTRACTOR has failed to supply personnel or resources and such failure results in CONTRACTOR's inability to fulfill its duties under the Agreement.

(5) *Termination for gifts and gratuities*.

(A) HHSC may terminate the Agreement following the determination by a competent judicial or quasi-judicial authority and CONTRACTOR's exhaustion of all legal remedies that CONTRACTOR, its employees, agents or representatives have either offered or given anything of value an officer or employee of HHSC or the State of Texas in violation of state law.

(B) CONTRACTOR must include a similar provision in each of its subcontracts and will enforce this provision against a subcontractor who has offered or given anything of value to any of the persons or entities described in this Section, whether or not the offer or gift was in CONTRACTOR's behalf.

(C) Termination of a subcontract by CONTRACTOR under this provision will not be a cause for termination of the Agreement unless:

(1) CONTRACTOR fails to replace such terminated subcontractor within a reasonable time; and

(2) Such failure constitutes Cause as described in this Section.

(D) For purposes of this Section, a "thing of value" means any item of tangible

or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment, and charitable contributions. The term does not include contributions to holders of public office or candidates for public office that are paid and reported in accordance with state or federal law.

(6) *Termination for non-appropriation of funds*.

Notwithstanding any other provision of the Agreement, if funds for the continued fulfillment of the Agreement by HHSC are at any time not forthcoming or are insufficient, through failure of any entity to appropriate funds or otherwise, then HHSC will have the right to terminate the Agreement at no additional cost and with no penalty whatsoever by giving prior written notice documenting the lack of funding.

(7) *Judgment and execution.*

(A) HHSC may terminate the Agreement if judgment for the payment of money in excess of $500,000.00 that is not covered by insurance, is rendered by any court or governmental body against CONTRACTOR, and CONTRACTOR does not:

(1) Discharge the judgment or provide for its discharge in accordance with the terms of the judgment;

(2) Procure a stay of execution of the judgment within 30 days from the date of entry thereof; or

(3) Perfect an appeal of such judgment and cause the execution of such judgment to be stayed during the appeal, providing such financial reserves as may be required under generally accepted accounting principles.

(B) If a writ or warrant of attachment or any similar process is issued by any court against all or any material portion of the property of CONTRACTOR, and such writ or warrant of attachment or any similar process is not released or bonded within 30 days after its entry, HHSC may terminate the Agreement in accordance with this Section.

(8) *Termination for CONTRACTOR'S material breach of the Agreement.*

HHSC will have the right to terminate the Agreement in whole or in part if HHSC determines, at its sole discretion, that CONTRACTOR has materially breached the Agreement.

Section 11.04 Effective date of termination.

Except as otherwise provided in the Agreement, termination will be effective as of the date specified in the notice of termination.

Section 11.05 Extension of termination effective date.

HHSC may extend the effective date of termination one or more times as it elects, in its sole discretion.

Section 11.06 Payment and other provisions at Agreement termination.

(a) If HHSC terminates the Agreement, 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.

(b) HHSC further agrees to negotiate in good faith with CONTRACTOR to equitably adjust and settle any accrued or outstanding liabilities for any unaccepted Service or deliverable and Change Order Requests that

(1) Is due or delivered prior to or upon contract termination;

(2) Is complete or substantially complete, or for which CONTRACTOR can document to the satisfaction of HHSC substantial progress; and

(3) Benefits HHSC or the State of Texas, notwithstanding its unaccepted status.

(c) CONTRACTOR must provide HHSC all reasonable access to records, facilities, and documentation as is required to efficiently and expeditiously close out the Services under the Agreement.

(d) CONTRACTOR must prepare a turnover plan, which is acceptable to and approved by HHSC. That turnover plan will be implemented during the time period between receipt of notice and the termination date.

Section 11.07 Modification of Agreement in the event of remedies.

HHSC may propose a modification of the Agreement in response to the imposition of a remedy under this article. Any modifications under this Section must be reasonable, limited to the matters causing the exercise of a remedy, and in writing. CONTRACTOR must negotiate such proposed modifications in good faith.

Section 11.08 Turnover assistance.

Upon receipt of notice of termination of the Agreement by HHSC, CONTRACTOR will provide any turnover assistance reasonably necessary to enable HHSC or its designee to effectively close out the Agreement and move the work to another vendor or to perform the work by itself.

Section 11.09 Rights upon termination or expiration of Agreement.

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 in whatever form that they exist.

Section 11.10 CONTRACTOR responsibility for associated costs.

If HHSC terminates the Agreement for Cause, the CONTRACTOR will be responsible to HHSC for all 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 and the cost of any claim or litigation that is reasonably attributable to CONTRACTOR's failure to perform any Service in accordance with the terms of the Agreement

Section 11.11 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 mutually commit 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 the Agreement may materially or substantially affect the performance of any Party will be reduced to writing and delivered to the other Party within 10 business days. The Parties must then negotiate in good faith and use every reasonable effort to resolve the dispute and the Parties will 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 will be reduced to writing and delivered to all Parties within 10 business days.

(c) *Claims for breach of Agreement.*

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

(2) *Negotiation of claims*. The Parties agree that the CONTRACTOR's claim for breach of the 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.

(A) To initiate the process, CONTRACTOR must submit written notice to HHSC that 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.

(B) The Parties 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.

(3) *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 Subsection (c)(2) of this Section.

(A) The Parties 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 the Agreement by HHSC nor any other conduct of any representative of HHSC relating to the Agreement will be considered a waiver of the state's sovereign immunity to suit.

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

(5) *CONTRACTOR's duty to perform.* Neither the occurrence of an event constituting an alleged breach of contract nor the pending status of any claim for breach of contract is grounds for the suspension of performance, in whole or in part, by CONTRACTOR of any duty or obligation with respect to the performance of the Agreement. Any changes to the Agreement as a result of a Dispute Resolution will be implemented in accordance with Article 8, Amendments, Modifications and Change Order Requests.

Section 11.12 Liability of CONTRACTOR.

(a) CONTRACTOR bears all risk of loss or damage due to:

(1) Defects in products, Services or Deliverables;

(2) Unfitness or obsolescence of products, Services or Deliverables; or

(3) The negligence or intentional misconduct of CONTRACTOR or its employees, agents, subcontractors, or representatives.

(b) 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 claim or action for property damage, 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.

(c) CONTRACTOR will not be liable to HHSC for any loss, damages or liabilities attributable to or arising from:

(1) The failure of HHSC or any state agency or HHSC CONTRACTOR to perform a service or activity in connection with the Agreement; or

(2) CONTRACTOR's prudent and diligent performance of the Services in compliance with instructions given by HHSC in accordance with Section 1.03 (relating to implied authority) and Section 3.03 (relating to delegation of authority) of the Agreement.

(d) CONTRACTOR will ship all Equipment and Software purchased and Third Party Software licensed under the Agreement, freight prepaid, FOB HHSC's destination. The method of shipment will be consistent with the nature of the Equipment and Software and hazards of transportation. Regardless of FOB point, CONTRACTOR agrees to bear all risks of loss, damage, or destruction of Deliverables, in whole or in part, ordered hereunder that occurs prior to Acceptance, except loss or damage attributable to HHSC's fault or negligence; and such loss, damage, or destruction will not release CONTRACTOR from any obligation hereunder. After Acceptance, the risk of loss or damage will be borne by HHSC, except loss or damage attributable to CONTRACTOR's fault or negligence.

Article 12. Assurances and Certifications

Section 12.01 Proposal 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 12.02 Conflicts of interest.

(a) *Representation.*

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 will not acquire any direct or indirect interest that would conflict in any manner or degree with its performance under the Agreement.

(b) *General duty regarding conflicts of interest.*

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

Section 12.03 Organizational conflicts of interest.

(a) *Definition.*

An organizational conflict of interest is a set of facts or circumstances, a relationship, or other situation under which a contractor, or a subcontractor has past, present, or currently planned personal or financial activities or interests that either directly or indirectly:

(1) Impairs or diminishes the offeror's, contractor's, or subcontractor's ability to render impartial or objective assistance or advice to HHSC; or

(2) Provides the contractor or subcontractor an unfair competitive advantage in future HHSC procurements.

(b) *Warranty.*

Except as otherwise disclosed and approved by HHSC prior to the Effective Date of the Contract, 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 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.

(c) *Continuing duty to disclose.*

(1) CONTRACTOR agrees that, if after the Effective Date, CONTRACTOR discovers is made aware of an organizational conflict of interest, CONTRACTOR will immediately and fully disclose such interest in writing to the HHSC project manager. 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.

(2) The disclosure will include a description of the action(s) that CONTRACTOR has taken or proposes to take to avoid or mitigate such conflicts.

(d) *Remedy.*

If HHSC determines that an organizational conflict of interest exists, HHSC may, at its discretion, terminate the contract. If HHSC determines that CONTRACTOR was aware of an organizational conflict of interest before the award of the Agreement and did not disclose the conflict to the contracting officer, such nondisclosure will be considered a material breach of the Agreement. Furthermore, such breach may be submitted to the Office of the Attorney General, Texas Ethics Commission, or appropriate state or federal law enforcement officials for further action.

(e) *Flow down obligation.*

CONTRACTOR must include the provisions of Section 12.02 and 12.03 in all subcontracts for work to be performed similar to the service provided by CONTRACTOR, and the terms "Agreement," "CONTRACTOR," and "project manager" modified appropriately to preserve the state's rights.

Section 12.04 HHSC personnel recruitment prohibition.

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 12.05 Anti-kickback provision.

CONTRACTOR certifies that it will comply with the Anti-Kickback Act of 1986, 41 USC §51-58 and Federal Acquisition Regulation 52.203-7.

Section 12.06 Debt or back taxes owed to the State of Texas.

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.

Section 12.07 Certification regarding status of license, certificate, or permit.

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.

Section 12.08 Outstanding debts and judgments.

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 Anti-trust.

In submitting a proposal, and in accepting the Contract or purchase order, Contractor certifies and agrees as follows:

(1) Neither the CONTRACTOR, nor the person represented by the CONTRACTOR, nor any person acting for the represented person has:

(a) violated the antitrust laws codified by Chapter 15, Business & Commerce Code, or the federal antitrust laws; or

(b) directly or indirectly communicated the bid/offer associated with this contract to a competitor or other person engaged in the same line of business.

(2) 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 contract.

Article 13. Representations and Warranties

Section 13.01 Authorization.

(a) The execution, delivery and performance of the Agreement has been duly authorized by CONTRACTOR and no approval, authorization or consent of any governmental or regulatory agency is required to be obtained in order for CONTRACTOR to enter into the Agreement and perform its obligations under the Agreement.

(b) CONTRACTOR has obtained and will 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. CONTRATOR will maintain all required certifications, licenses, permits, and authorizations during the term of the Agreement.

Section 13.02 Ability to perform.

CONTRACTOR warrants that it has the financial resources to fund the capital expenditures required under the Agreement without advances by HHSC or assignment of any payments by HHSC to a financing source.

Section 13.03 Workmanship and performance.

(a) All Services and Deliverables provided under the Agreement will be provided in a manner consistent with the standards of quality and integrity as outlined in the Agreement, the RFP, and CONTRACTOR's Proposal.

(b) All Services and Deliverables must meet or exceed the required levels of performance specified in or under the Agreement, and will meet or exceed HHSC's Missions and Objectives, as set forth in the RFP.

(c) CONTRACTOR will perform the Services in a workmanlike manner, in accordance with best practices and high professional standards used in well-managed operations performing services similar to the services described in the Agreement.

Section 13.04 Warranty of deliverables.

CONTRACTOR warrants that Deliverables developed and delivered under the Agreement will meet the Specifications as described in the Agreement during the period following its acceptance by HHSC, through the term of the Agreement, including any extensions as provided in the Agreement, that are subsequently negotiated by CONTRACTOR and HHSC. CONTRACTOR will promptly repair or replace any such Deliverables not in compliance with this warranty at no charge to HHSC.

Section 13.05 Manufacturers' warranties.

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 13.06 Compliance with Agreement.

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.

Article 14. Intellectual Property

Section 14.01 Infringement and misappropriation.

(a) 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.

(b) 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.

(c) 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.

Section 14.02 Exceptions.

CONTRACTOR is not responsible for any claimed breaches of the warranties set forth in Section 14.01 to the extent caused by:

(a) Modifications made to the item in question by anyone other than CONTRACTOR or its subcontractors or HHSC or its Contractors working at CONTRACTOR's direction or in accordance with the specifications; or

(b) The combination, operation, or use of the item with other items if CONTRACTOR did not supply or approve for use with the item; or

(c) HHSC's failure to use any new or corrected versions of the item made available by CONTRACTOR.

Article 15. Liability

Section 15.01 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 encourage its employees and agents to observe safety measures and proper operating procedures at HHSC sites at all times.

(c) CONTRACTOR will distribute a policy statement to all of its employees and agents that directs the employee or agent to immediately report to HHSC or to CONTRACTOR any special defect or unsafe condition encountered while on HHSC premises. CONTRACTOR will immediately report to HHSC any special defect or an unsafe condition it encounters or otherwise learns about.

Section 15.02 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 15.03 Limitation of HHSC's Liability.

HHSC WILL NOT BE LIABLE FOR ANY INCIDENTAL, INDIRECT, SPECIAL, OR CONSEQUENTIAL DAMAGES UNDER CONTRACT, TORT (INCLUDING NEGLIGENCE), OR OTHER LEGAL THEORY. THIS WILL APPLY REGARDLESS OF THE CAUSE OF ACTION AND EVEN IF HHSC HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

HHSC'S LIABILITY TO CONTRACTOR UNDER THE AGREEMENT WILL NOT EXCEED THE TOTAL CHARGES TO BE PAID BY HHSC TO CONTRACTOR UNDER THE AGREEMENT, INCLUDING CHANGE ORDER REQUEST PRICES AGREED TO BY THE PARTIES OR OTHERWISE ADJUDICATED.

Article 16. Special Terms and Conditions

The following provisions may apply to this contract if noted in the Contract Agreement.

Note: Section 16.08 Historically Underutilized Business Participation Requirements APPLIES IF *HHSC* determined that sub-contracting opportunities were probable for the procurement/contract.

Section 16.01 HIPAA.

If the Data Use Agreement is attached, it is incorporated by reference into the Agreement.

Section 16.02 Member records.

CONTRACTOR and any subcontractor may not transfer an identifiable Member record, including a patient record, to another entity or person without written consent from the Member or someone authorized to act on his or her behalf; however, HHSC may require CONTRACTOR, or any subcontractor, to transfer a Member record to another agency or to HHSC if the transfer is necessary to protect either the confidentiality of the record or the health and welfare of the Member.

If at any time during the Initial Term, the Agreement is terminated, HHSC may require the transfer of Member records, upon written notice to CONTRACTOR, to another entity that agrees to continue performance of the Agreement, as consistent with federal and state laws and applicable releases.

The term "Member Record" for this Section 16.03 means only those administrative, enrollment, case management and other such records maintained by CONTRACTOR and is not intended to include patient records maintained by participating network providers.

Section 16.03 Financial/performance audits.

(a) Texas Health and Safety Code Section 12.0123 directs HHSC to contract with an independent auditor to perform annual independent external financial and performance audits of any Medicaid vendor used by HHSC in HHSC's operation of a part of the state Medicaid program. "Medicaid vendor" 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.

(b) CONTRACTOR agrees to deliver to HHSC, for HHSC's approval, a Corrective Action Plan that addresses deficiencies identified in the audit within 30 calendar days of the delivery of the independent auditor's report.

(c) CONTRACTOR understands that the independent auditor ("the auditor") will make specific inquiries of CONTRACTOR'S management for information, including but not limited to information concerning the representations embodied in the

financial statements and reports CONTRACTOR is required to furnish the state as per the “Financial Report Requirements” requirements of the Contract.. CONTRACTOR understands that as part of the auditor’s audit procedures, the auditor will request, and CONTRACTOR’S management will provide to the auditor a representation letter;

(1) Acknowledging management’s responsibility for the preparation of the financial statements and reports;

(2) Acknowledging management’s responsibility for compliance with laws and regulations; and

(3) Affirming management’s belief that the effects of any uncorrected financial statement or report misstatements aggregated by the auditor during the current audit engagement and pertaining to the period presented are immaterial, both individually and in the aggregate, to the financial statements and reports taken as a whole.

(d) 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.

Section 16.04 Audit software.

As part of the Services, CONTRACTOR must operate and maintain audit software that HHSC or its designees may provide to CONTRACTOR from time to time during the Term of the Agreement.

Section 16.05 Ownership and licenses.

(a) *Custom software.*

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

(b) *Ownership rights.*

(1) 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 and the associated Documentation for purposes of this Section. CONTRACTOR will take all actions necessary and transfer ownership of the Deliverables to HHSC, including the Custom Software and associated Documentation on Final Acceptance or as otherwise provided in the Agreement.

(2) 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.

(3) CONTRACTOR will, at the expense of HHSC, assist HHSC or its nominees 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.

(c) *License Rights*

HHSC will have ownership and unlimited rights to use, disclose, duplicate, or publish all information and data developed, derived, documented, or furnished by CONTRACTOR under or resulting from the Agreement. Such data will include all results, technical information, and materials developed for or obtained by 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.

(d) *Proprietary Notices*

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.

(e) *Third Party Software and Documentation Licenses*

(1) CONTRACTOR grants HHSC a non-exclusive, perpetual, license for HHSC to use the Third Party Software and its associated Documentation for its internal business purposes. HHSC will be entitled to use the Third Party Software on the Equipment or any replacement equipment used by HHSC, and with any

replacement Third Party Software chosen by HHSC, without additional Charges. Terms in any licenses for Third Party Software will be consistent with the requirements of this Section.

(2) The licenses hereunder are granted as of the date when such Third Party Software is installed and certified by CONTRACTOR as operational, and the licenses will continue until HHSC permanently discontinues the use of the Third Party Software.

(3) Prior to utilizing any 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 that must, at a minimum, provide HHSC with necessary rights consistent with the short and long-term goals of the Agreement. CONTRACTOR will assign to HHSC the licenses for the Third Party Software upon Final Acceptance.

(4) CONTRACTOR will, during the Project, maintain any and all Third Party Software products at their most current version or no more than one version back from the most current version. However, CONTRACTOR will not maintain any Third Party Software versions, including one version back, if any such version would prevent HHSC from using any functions, in whole or in part, or would cause Deficiencies in the System.

(f) *State and Federal Governments*

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 for Federal Government purposes 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.

Section 16.06 Insurance Coverage.

(a) *Required Coverage.*

(1) CONTRACTOR will procure, at CONTRACTOR's own expense, during the Term of the Agreement and until final acceptance of all Services and Deliverables, the following insurance coverage. CONTRACTOR will provide HHSC with proof of the following insurance coverage within 10 calendar days after the Agreement is awarded upon HHSC's request:

(A) Standard Worker's Compensation Insurance coverage;

(B) Automobile Liability; and

(C) Commercial General Liability Insurance including Bodily Injury coverage of $100,000.00 per each occurrence and Property Damage Coverage of $25,000.00 per each occurrence.

(2) If CONTRACTOR's current Commercial General Liability insurance coverage does not meet the above stated requirements, CONTRACTOR will obtain excess liability insurance to compensate for the difference in the coverage amounts.

(3) CONTRACTOR is responsible for all deductibles stated in the policies. Insurance will be maintained at all times during the performance of the Agreement. Insurance coverage will be issued by insurance companies authorized by applicable law to conduct business in the State of Texas, and must name HHSC as an additional insured.

(4) The policy will have an extended reporting period of two years. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede, start of work on the Agreement.

(b) *Proof of Insurance Coverage*

(1) CONTRACTOR will furnish the HHSC Project Manager original Certificates of Insurance evidencing the required coverage to be in force on the date of award, and renewal certificates of insurance, or such similar evidence, if the coverages have an expiration or renewal date occurring during the term of the Agreement. The failure of HHSC to obtain this evidence from CONTRACTOR before permitting CONTRACTOR to commence work will not be deemed to be a waiver by HHSC and CONTRACTOR will remain under continuing obligation to maintain and provide proof of the insurance coverage.

(2) The insurance specified above will be carried until all services required to be performed under the terms of the Agreement are satisfactorily completed. Failure to carry or keep such insurance in force will constitute a violation of the Agreement, and HHSC maintains the right to stop work until proper evidence of insurance is provided.

(3) The insurance will provide for 30 calendar days prior written Notice to be given to HHSC in the event coverage is substantially changed, canceled, or non-renewed. CONTRATOR must submit a new coverage binder to HHSC to ensure no break in coverage.

(4) CONTRACTOR will require all subcontractors operating in Texas to carry the same or more coverage as CONTRACTOR is required to carry under the Agreement. CONTRACTOR may provide the coverage for any subcontractor, and, if provided, the evidence of insurance submitted will so stipulate.

(5) The Parties understand and agree that any insurance coverages and limits furnished by CONTRACTOR will in no way expand or limit CONTRACTOR's liabilities and responsibilities

specified within the Contract documents or by applicable law.

(6) CONTRACTOR and each subcontractor will require that insurer will waive their rights of subrogation against HHSC.

(7) CONTRACTOR understands and agrees that any insurance maintained by HHSC will apply in excess of and not contribute with insurance provided by CONTRACTOR under the Agreement.

(8) If CONTRACTOR, or its subcontractor(s), desire additional coverage, higher limits of liability, or other modifications for its own protection, CONTRACTOR and each of its subcontractors will be responsible for the acquisition and cost of this additional protection at no additional cost to HHSC.

(9) CONTRACTOR may not transport a client or conduct any other official business on behalf of HHSC without the required coverage of the Agreement. CONTRACTOR agrees and understands that HHSC will not be liable for any accident or death due to an automobile accident involving the CONTRACTOR or CONTRACTOR's employee, even if the accident or death occurs in the course of performing any work under the Agreement. Failure to meet this provision may be considered a material breach of the Agreement.

Section 16.07 Background Checks.

CONTRACTOR must obtain a criminal background check, including fingerprints in a form and of a quality acceptable to the Department of Public Safety and the Federal Bureau of Investigation, on any employees, including Subcontractors and Subcontractor employees, who would be placed in direct contact with a resident or client.

CONTRACTOR must also perform checks against the Nurse Aide Registry and the Employee Misconduct Registry maintained on DADS' Employability Status Check Search website. CONTRACTOR must perform any criminal background checks at its expense and should limit its search to the United States of America.

CONTRACTOR will not utilize an employee, Subcontractor, or Subcontractor's employee to perform a site visit or have any contact with stakeholders, patients, residents, or their family members if:

(a) CONTRACTOR determines, as a result of a criminal background check, that the person has been convicted of an offense listed in Tex. Health & Safety Code § 250.006 that bars employment or if the Consultant makes a reasonable determination that a conviction may pose a risk to any stakeholders, patients, residents, or their family members; or

(b) the employee or Subcontractor or Subcontractor's employee is listed in the Nurse Aide Registry or the Employee Misconduct Registry.

Section 16.08 Historically Underutilized Business Participation Requirements

This Subsection applies if HHSC determined that sub-contracting opportunities were probable for the procurement/contract.

(a) Definitions.

For purposes of this Section:

(1) **"Historically Underutilized Business"** or **"HUB"** means a minority or women-owned business as defined by Texas Government Code, Chapter 2161.

(2) **"HSP"** means a HUB Subcontracting Plan.

(b) HUB Requirements.

(1) Contractor must submit an HSP for HHSC's approval.

(2) Contractor must report to HHSC's contract manager and HUB Office monthly, in the format required by the HUB Office, its use of HUB subcontractors to fulfill the subcontracting opportunities identified in the HSP.

(3) If the Parties amend the Agreement to include additional funds or a change to the Scope of Work, the Contractor must submit a revised HSP to the HHSC HUB Office, when a determination is made for additional subcontracting opportunities. All proposed changes to the HSP must comply with the requirements of **Section 16.08(b)(4).**

(4) Contractor must obtain prior written approval from the HHSC HUB Office before making any changes to the HSP. The proposed changes must comply with HHSC's good faith effort requirements relating to the development and submission of HSPs.

(5) HHSC will determine if the value of Subcontracts to HUBs meet or exceed the HUB subcontracting provisions specified in the Contractor's HSP. If HHSC determines that the Contractor's subcontracting activity does not demonstrate a good faith effort, the Contractor may be subject to provisions in the Vendor Performance and Debarment Program (34 Tex. Admin. Code Chapter 20, Subchapter C), and subject to remedies for Breach.

AGREEMENT BETWEEN THE
TEXAS HEALTH AND HUMAN SERVICES COMMISSION
AND
LOGISTICARE SOLUTIONS, LLC

EXHIBIT E
DEFINITIONS

Definition additions, modifications and deletions

The following definitions are in addition to those in RFP Attachment B

MT88 MTO Network File	File provided by each MTO, which contains data detailing providers and participants contracting with the MTO for their plan for each region.
MTO Combined Master Provider File	File containing provider information for medical, pharmacy, and MTP providers that are enrolled with TMHP.
TXMedcentral	Bulletin Board System (BBS) used to submit claims, check enrollment, encounter, etc. by providers. This is a secure server that is used to exchange information with trading partners.

The following definitions in RFP Attachment B are deleted

Non-Emergency Ambulance Transportation Services	Transportation provided by ambulance in a nonemergency situation when all other means of transportation are not suitable for transporting the client to a covered medical care or other health care service. Nonemergency ambulance transportation does not include any medical monitoring, medical aid, medical care, or medical treatment during transport. No flashing lights, sirens, or emergency equipment is required. See Section 2.3.9 of this RFP for other provisions.
Stretcher Service	Service for clients who cannot be transported in a taxi or wheelchair van but do not require the medical services of an ambulance. Clients generally cannot use a seat in the vertical position and must use a stretcher during transport. Client must be medical stable to be transported by stretcher service.

The following definitions in RFP Attachment B are modified

Frew class Members	Refers to children, under 21 years of age, enrolled in Texas Medicaid (see Frew).
Individual Transportation Participant (ITP)	An individual who has been approved by MTO for mileage reimbursement at a prescribed rate to provide transportation for a prior authorized MTP client to a prior authorized heath care service.
Lodging	A commercial establishment enrolled with the MTO that provides overnight lodging at a negotiated rate.
Material Subcontract	Any contract, subcontract, or agreement between the Contractor and another entity that meets *any* of the following criteria: • the other entity is an Affiliate of the Contractor; • the subcontract is considered by HHSC to be for a key type of service or function; or • any other subcontract that exceeds, or is reasonably expected to exceed, the lesser of: (a) $100,000 per year, or

	(b) 1% of the Contractor's annual Revenues under this Agreement. Any subcontracts between the MTO and a single entity that are split into separate agreement by time period, will be consolidated for the purpose of this definition.
Performing Provider	The entity that arranges or provides transportation services to an eligible MTP client (other than ITPs), including, subcontractors, independent contractors, lodging and meal vendors, and intercity bus services.
Public Transportation	Mass transportation of passengers and their hand-carried packages or baggage on a regular and continuing basis by means of surface, fixed guide way, or underground transportation or transit, other than aircraft, or taxicab vehicle.

AGREEMENT BETWEEN THE
TEXAS HEALTH AND HUMAN SERVICES COMMISSION
AND
LOGISTICARE SOLUTIONS, LLC

EXHIBIT F

HHSC's Request for Proposals # 529-15-0002, and its Addenda and Attachment, as supplemented and modified

529-15-0002 RFP & Attachments.zip

Kyle L. Janek, M.D., Executive Commissioner

Request for Proposals (RFP)
for
Nonemergency Medical Transportation Services

RFP No. 529-15-0002

Date of Release: November 25, 2013

CPA Class/Item Codes:

948 - Item 07: Administration Services, Health
952 - Item 59: Human Services
952 - Item 94: Transportation Services for Elderly, Handicapped, Incapacitated, Prisoners, Juries, etc.
961 - Item 82: Transportation Services (Not Otherwise Classified)
915 - Item 49: High Volume, Telephone Call Answering Services (See 915-05 for low volume Services)
918 - Item 96: Transportation Consulting
958 - Item 91: Transit Management Services

Table of Contents

1. General Information

1.1 Scope

In accordance with Federal Regulation, 42 Code of Federal Regulation (C.F.R.) Part 431.53, the State Medicaid program is required to provide for the establishment of Nonemergency Medical Transportation (NEMT) for eligible clients who need transportation services to covered medical care or other health care services and have no other means of transportation.

The State of Texas by and through the Texas Health and Human Services Commission (HHSC) seeks to enhance the delivery, financial, business, and technical solutions of transportation services through the establishment of Managed Transportation Organizations (MTOs) and Transit Service Delivery models.

To meet the requirements of Senate Bill 8, 83rd Legislature, Regular Session (2013), HHSC intends to award contracts to obtain an MTO in each region who will provide transportation services to eligible clients in their region under a capitated rate system and assume financial responsibility under a full-risk model. The projected implementation date is September 1, 2014.

HHSC will review the proposals to confirm that the requirements of Senate Bill 8 are met and will not jeopardize compliance with *Frew, et al., v. Janek, et al., Civil Action No: 3:93CV65* (*Frew).* Services must also satisfy requirements under the 1996 Consent Decree, and the 2007 Corrective Action Orders (CAO). These orders are in effect and will be referred to in this Request for Proposal (RFP). Each respondent to this RFP is responsible for becoming aware of the requirements of each. Copies of the Consent Decree and CAO are available from the following addresses:

- https://www.hhsc.state.tx.us/medicaid/**frew**/**consent**-**decree**.shtml
- http://www.hhs.state.tx.us/MotionCorrectiveActions/

Respondents must consider how *Frew* requirements will affect organizational structure and service delivery, and must demonstrate how those requirements will be satisfied in their proposal. A proposal that fails to specifically address *Frew* obligations and explain how it will meet *Frew* requirements cannot be considered for award.

1.2 HHSC Point of Contact

The sole point of contact for inquiries concerning this RFP is:

Robert Hall, C.P.M., CTPM, CCA
Procurement and Contracting Services (PCS Division)
Texas Health and Human Services Commission
4405 N Lamar Blvd.
Austin, TX 78756
Phone: (512) 206-5526
Fax: (512) 206-5552
robert.hall@hhsc.state.tx.us

All communications relating to this RFP must be directed to the HHSC contact person named above. Respondents may email questions for the conference to the HHSC Point of Contact (see Section 1.2) no later than five (5) days before the conference for potential responses at the vendor conference. All communications between respondents and other HHSC staff members concerning this RFP are strictly prohibited. **Failure to comply with these requirements may result in proposal disqualification.**

Procurement Schedule

The following table documents the critical pre-award events for the procurement. All dates are subject to change at HHSC's discretion.

Procurement Schedule	
RFP Release Date	***11-25-2013***
Vendor Conference	***12-10-2013***
Vendor Questions Due	***12-13-2013***
HHSC Posts Responses to Vendor Questions	***12-19-2013***
Proposals Due	***01-15-2014***
Deadline for Proposal Withdrawal	***01-15-2014***
Tentative Award Announcement	***03-01-2014***
Anticipated Contract Start Date	***07-31-2014***

1.4 Mission Statement

HHSC's mission for this procurement is to establish a statewide network of qualified, MTOs that will offer quality, safe, timely and economical transportation services to eligible clients that have no other means of transportation to obtain medical care or other health care services.

1.5 Mission Objectives

HHSC's objectives for this procurement are to:

- Comply with the requirements of Senate Bill 8.

- Establish a qualified MTO in each MTO Region to provide transportation services to eligible clients that have no other means of transportation to obtain medical care or other health care services. (See Attachment A, Regional Designations).

- Ensure that eligible clients of the Medical Transportation Program (MTP) have safe and timely access to transportation services to covered medical care or other health care services.

- Offer quality service that is appropriate and economically feasible based on client health care needs.

- Increase program efficiencies through the establishment of a regional network of transportation providers.

- Eliminate potential for fraud, waste and abuse.

- Reduce the cost of medical transportation by utilizing a capitation payment methodology.

- Increase efficiencies through data analytics collected and reported by providers and analyzed by HHSC.

- Comply with obligations of the *Frew L*awsuit.

1.6 Background

1.6.1 Overview of the Health and Human Services Commission

Since 1991, the Texas Health and Human Services Commission (HHSC) has overseen and coordinated the planning and delivery of health and human service programs in Texas. HHSC is established in accordance with Texas Government Code Chapter 531, and is responsible for the oversight of all Texas health and human service agencies (HHS Agencies). HHSC's chief executive officer is Kyle L. Janek, M.D., Executive Commissioner of Health and Human Services.

1.6.2 Project Overview

The Texas Medical Transportation Program (MTP) is responsible for arranging and administering cost-effective, nonemergency medical transportation (NEMT) services to eligible Medicaid clients, Children with Special Health Care Needs (CSHCN) Services Program clients and Transportation for Indigent Cancer Patients (TICP) who are diagnosed with cancer or cancer-related illness and meet program financial and residential eligibility criteria and who have no other means of transportation.

The MTP is responsible for ensuring that necessary nonemergency transportation services are provided in a manner that is:

- Similar in scope and duration for all clients in a group;

- Consistent with the best interest of clients;
- Appropriate to available services, geographic location, and limitation of clients;
- Reasonably prompt;
- Cost effective; and
- Administratively efficient.

To ensure necessary transportation for clients to and from visits with enrolled providers, MTP utilizes several transportation methods that comply with federal regulations that are efficient, cost effective, and meet client needs.

Senate Bill 8, 83rd Legislature, Regular Session (2013), amended Texas Government Code Chapter 533 to add section 533.00257 that employs Managed Transportation Organizations (MTOs) to change the manner in which medical transportation services will be delivered, effective September 1, 2014. The bill creates MTOs as one vehicle to provide the service. HHSC is required to competitively procure medical transportation services on a regional basis for a model of NEMT transportation delivery using MTOs.

Section 533.00257(h) authorizes HHSC to enter into agreements for a Transit Service Delivery model performed in qualifying contiguous counties within a managed transportation service region. HHSC will consider competitive proposals from qualified legal entities that commit to arranging for all of the services and meeting all of the requirements of this RFP in either one or more of the transportation service regions included in the scope of the RFP. HHSC will enter into a single contract in each transportation service region. If multiple entities qualified pursuant to Section 533.00257(h) wish to offer a proposal to serve a service region, they must propose as a single legal entity.

The shift in the types of transportation service delivery models also includes a change in the payment structure that requires providers to operate under a capitated rate structure and assume financial responsibility under a full risk model. Additionally, MTOs will be required to offer the following transportation services:

- Demand response transportation (including cars, vans and ambulette vehicles)
- Mass transit tickets
- Individual Transportation Participants (ITP)
- Meals and lodging
- Advanced funds
- Out-of-State travel
- Attendant services
- Commercial airline transportation services
- Nonemergency ambulance transportation
- Call center operations

1.7 Strategic Elements

1.7.1 Contract Type and Term

HHSC will award multiple contracts across the State, selecting one vendor per MTO Region. Vendors may apply for, and may be awarded contracts for, multiple MTO Regions. Vendors must submit one proposal response for each MTO Region in which they wish to be considered. (See Attachment A, Regional Designations). The initial

contract period will be for a term of three (3) years. HHSC reserves the option to extend the term of the contract for up to two (2) additional one (1) year terms, or as necessary to complete the mission of the procurement.

1.7.2 Contract Elements

The term "contract" means the contract awarded as a result of this RFP and all attachments thereto. At a minimum, the following documents will be incorporated into the contract: this RFP and all attachments; any modifications, addendum or amendments issued in conjunction with this RFP; HHSC's Data Use and Business Associate Agreement (see Attachment T); HHSC's Uniform Contract Terms and Conditions (UTCs), Version 1.4.1,as modified or amended and the successful respondent's proposal.

One or more of the "Special Terms" located in Article 16 of the UTCs may apply to the contract, and HHSC reserves the right to negotiate additional contract terms and conditions. Respondents are responsible for reviewing the UTCs and noting any exceptions, reservations, and limitations on the Respondent Information and Disclosures form.

1.7.3 HHSC's Basic Philosophy: Contracting for Results

HHSC's fundamental commitment is to contract for results. HHSC defines a successful result as the generation of defined, measurable, and beneficial outcomes that satisfy the contract requirements and support HHSC's missions and objectives. This RFP describes what is required of the MTO in terms of services, deliverables, performance measures and outcomes, and unless otherwise noted in the RFP, places the responsibility for how they are accomplished on the MTO. Failure to achieve performance measures outlined in this RFP could result in corrective action and/or the assessment of liquidated damages. (See Attachment S, MTO Key Performance Requirements).

1.8 External Factors

External factors may affect the project, including budgetary and resource constraints. Any contract resulting from the RFP is subject to the availability of state and federal funds. As of the issuance of this RFP, HHSC anticipates that budgeted funds will be available to reasonably fulfill the project requirements. If, however, funds are not available, HHSC reserves the right to withdraw the RFP or terminate the resulting contract without penalty.

1.9 Legal and Regulatory Constraints

1.9.1 *Frew*, et al., v. Janek et al., Civil Action No: 3:93CV65 (*Frew*)

Filed in 1993 and certified as a class action in 1994, this suit challenged the State of Texas' provision of services to children on Medicaid, birth through age 20. The suit was brought to enhance the availability of health care services, effectively inform clients that services are available and eliminate barriers that have the effect of preventing access to service, such as inadequate transportation. The contention was that many children who

receive Medicaid do not receive needed services simply because they have no way to get there. Nonemergency transportation service is meant to address this need.

The Plaintiff class is comprised of Medicaid clients, birth through age 20, that have not received all of the Texas Health Steps services to which they are entitled, unless the services were declined. Services to children with Medicaid account for approximately forty percent of the nonemergency transportation services call volume.

Texas reached agreements with Plaintiffs in the lawsuit and those agreements are covered in the Consent Decree and CAO's. The CAO Toll Free Numbers specifies that when the State enters into new contracts for provision of toll free number services, the contracts will include the CAO promptness standards. In addition to the CAO standards, the respondent will be required to meet the obligations as set forth in the Consent Decree for transportation services and toll-free lines.

Each proposal must incorporate plans to meet the *Frew* obligations as specified in Section 2.36.

The MTO must have vehicles that comply with all applicable state and federal laws, including the Americans with Disabilities Act (ADA) Accessibility Guidelines for Transportation Vehicles (36 C.F.R. 1192), Federal Motor Vehicle Safety Standards (49 C.F.R. 571), and Chapter 547 of the Texas Transportation Code.

1.9.2 Delegation of Authority

State and federal laws generally limit HHSC's ability to delegate certain decisions and functions to a contractor, including but not limited to: (1) policy-making authority, and (2) final decision-making authority on the acceptance or rejection of contracted services.

1.9.3 Conflicts of Interest

A conflict of interest is a set of facts or circumstances in which either a respondent or anyone acting on its behalf in connection with this procurement has past, present or currently planned personal, professional or financial interests or obligations that, in HHSC's determination, would actually or apparently conflict or interfere with the respondent's contractual obligations to HHSC. A conflict of interest would include circumstances in which a party's personal, professional or financial interests or obligations may directly or indirectly:

- Make it difficult or impossible to fulfill its contractual obligations to HHSC in a manner that is consistent with the best interests of the State of Texas;
- Impair, diminish or interfere with that party's ability to render impartial or objective assistance or advice to HHSC; or
- Provide the party with an unfair competitive advantage in future HHSC procurements.

Neither the respondent nor any other person or entity acting on its behalf, including but not limited to Performing Providers, employees, agents and representatives, may have a conflict of interest with respect to this procurement. Before submitting a proposal,

respondents should carefully review Article 12 of the Uniform Terms and Conditions for additional information concerning conflicts of interests.

A respondent must certify that it does not have personal or business interests that present a conflict of interest with respect to the RFP and resulting contract (See Attachment M). Additionally, if applicable, the respondent must disclose all potential conflicts of interest. The respondent must describe the measures it will take to ensure that there will be no actual conflict of interest and that its fairness, independence and objectivity will be maintained (See Attachment M). HHSC will determine to what extent, if any, a potential conflict of interest can be mitigated and managed during the term of the contract. **Failure to identify potential conflicts of interest may result in HHSC's disqualification of a proposal or termination of the contract.**

If the circumstances certified by Respondent change or additional information is obtained subsequent to submission of proposals, by submitting a response Respondent agrees that it is under a continuing duty to supplement its response under this provision, and Respondent shall submit updated information as soon as reasonably possible upon learning of any change to their affirmation.

1.9.4 Former Employees of a State Agency

Respondents must comply with Texas and federal laws and regulations relating to the hiring of former state employees (see e.g., Texas Government Code §572.054 and 45 C.F.R. Part 74.43). Such "revolving door" provisions generally restrict former agency heads from communicating with or appearing before the agency on certain matters for two years after leaving the agency. The revolving door provisions also restrict some former employees from representing clients on matters that the employee participated in during state service or matters that were in the employees' official responsibility.

As a result of such laws and regulations, a respondent must certify that it has complied with all applicable laws and regulations regarding former state employees (See Section 3.17.1.7, Required Certifications Form). Furthermore, a respondent must disclose any relevant past state employment of the respondent's or its Performing Providers' employees and agents in the Respondent Information and Disclosure form.

1.10 HHSC Amendments and Announcements Regarding this RFP

HHSC will post all official communication regarding this RFP on its website, including the notice of tentative award. HHSC reserves the right to revise the RFP at any time. Any changes, amendments, or clarifications will be made in the form of written responses to respondent questions, amendments, or addendum issued by HHSC on its website. Respondents should check the website frequently for notice of matters affecting the RFP. To access the website, go to the "HHSC Contracting Opportunities" page and enter a search for this procurement. The Respondent's failure to periodically check the Electronic State Business Daily (ESBD) will in no way release the selected vendor from "addenda or additional information" resulting in additional costs to meet the requirements of this RFP.

1.11 RFP Cancellation/Partial Award/Non-Award

HHSC reserves the right to cancel this RFP, to make a partial award, or to make no award if it determines that such action is in the best interest of the State of Texas.

1.12 Right to Reject Proposals or Portions of Proposals

HHSC may, in its discretion, reject any and all proposals or portions thereof.

1.13 Costs Incurred

Respondents understand that issuance of this RFP in no way constitutes a commitment by HHSC to award a Contract or to pay any costs incurred by a respondent in the preparation of a response to this RFP. HHSC is not liable for any costs incurred by a respondent prior to issuance of or entering into a formal agreement, contract, or purchase order. Costs of developing proposals, preparing for or participating in oral presentations and site visits, or any other similar expenses incurred by a respondent are entirely the responsibility of the respondent, and will not be reimbursed in any manner by the State of Texas.

1.14 Protest Procedures

Texas Administrative Code, Title 1, Part 15, Chapter 392, Subchapter C outlines HHSC's respondent protest procedures.

1.15 Interpretive Conventions

Whenever the terms "shall," "must," or "is required" are used in this RFP in conjunction with a specification or performance requirement, the specification or requirement is mandatory. A respondent's failure to address or meet any mandatory requirement in a proposal may be cause for HHSC's rejection of the proposal.

Whenever the terms "can," "may," or "should" are used in this RFP in conjunction with a specification or performance requirement, the specification or performance requirement is desirable, but not a mandatory requirement. Accordingly, a respondent's failure to address or provide any items so referred to will not be the cause for rejection of the proposal, but will likely result in a less favorable evaluation.

1.16 Vendor Procurement Strategy and Approach

This procurement is conducted as a competitive negotiation in accordance with HHSC administrative rules, 1 Tex. Admin. Code Ch. 391. Section 2155.144, Texas Government Code obligates HHSC to purchase goods and services on the basis of best value. HHSC rules define "best value" as the optimum combination of economy and quality that is the result of fair, efficient, and practical procurement decision-making and that achieves health and human services procurement objectives (see 1 Tex. Admin. Code §391.31). As stated in 1 Tex. Admin. Code § 391.121, HHSC may consider any of the following factors in determining best value:

(1) Any installation costs;

(2) The delivery terms;
(3) The quality and reliability of the vendor's goods or services;
(4) The extent to which the goods or services meet the agency's needs;
(5) Indicators of probable vendor performance under the contract such as past vendor performance, the vendor's financial resources and ability to perform, the vendor's experience and responsibility, and the vendor's ability to provide reliable maintenance agreements;
(6) The impact on the ability of the agency to comply with laws and rules relating to historically underutilized businesses or relating to the procurement of goods and services from persons with disabilities;
(7) The total long-term cost to the agency of acquiring the vendor's goods or services;
(8) The cost of any employee training associated with the acquisition;
(9) The effect of an acquisition on agency productivity;
(10) The acquisition price;
(11) The extent to which the goods or services meet the needs of the client(s) for whom the goods or services are being purchased; and
(12) Any other factor relevant to determining the best value for the agency in the context of a particular acquisition that is sufficiently described in a solicitation instrument.

HHSC will evaluate proposals using the criteria listed in order of precedence in Section 5 of this RFP.

2. Scope of Work

The mission of the Medical Transportation Program (MTP) is to provide a statewide network of qualified regional providers for transportation services that offers quality, safe, timely and economically feasible medical transportation services to eligible individuals that have no other means of transportation to obtain medical care or other health care services. The program will be structured to meet state and federal requirements regarding transportation services.

Through this RFP, the Health and Human Services Commission (HHSC) will award multiple contracts across the State, selecting one vendor per MTO Region. Respondents may apply for, and may be awarded contracts for, multiple MTO Regions to improve the efficiency and effectiveness of program operations by administering the daily functions of the MTP NEMT program operations in each of the MTO regions. Respondents may not submit multiple proposal responses for a given MTO Region. Respondents may apply for multiple MTO Regions; if so, they must a separate proposal response for each MTO Region in which they are interested.

2.1 Proposed Project Schedule

The following table documents the critical events for implementation of the new transportation service delivery models. All dates are subject to change at HHSC's discretion.

HHSC Telecommunications Infrastructure Development	03-01-2014 - 07-31-2014

MTO Administrative Development (staffing, client materials, policy development)	03-20-2014 - 05-01-2014
HHSC Training MTO	04-01-2014 - 05-01-2014
Trading Partner Testing	04-01-2014 - 06-01-2014
MTO System Development (provider network, IT infrastructure)	04-03-2014 - 05-30-2014
Operational, IT and Financial Readiness Reviews (desk and onsite)	05-30-2014 - 07-1-2014
Call Center Readiness Review	07-01-2014
Final Determination of MTO Readiness Review	07-15-2014
MTO Operational Start Date	08-01-2014

2.2 Project Scope

HHSC is interested in obtaining responses from qualified MTOs that address specifications detailed in this document and is in conformance with state and federal laws, agency rules, policies and procedures, including, but not limited to: 42 C.F.R. Part 431, §431.53 (Assurance of Transportation), Chapter 32 of the Texas Human Resource Code (HHSC's Authority to Establish Medical Transportation Program); Chapter 35 of The Texas Health and Safety Code and 42 U.S.C. 701 (Authorizing Service for Children with Special Health Care Needs); Texas Human Resources Code, Section 22.002(f) (HHSC's Authority to Contract for Medical Transportation Services); Texas Administrative Code, Title 1, Part 15, Chapter 380 (Medical Transportation Rules and Transportation for Indigent Cancer Patients (TICP)) and Title 25, Part 1, Chapter 38 (Transportation for Children with Special Health Care Needs); 42 C.F.R. Part 160 and Parts A & E of 164 (HIPAA); 42 U.S.C. 1396a(a)(68), (Compliance with the False Claims Act); Texas Government Code, Section 531.02414 (Medical Transportation Program Administration).

The requirements of 42 C.F.R. Part 440, §440.170 prohibit an MTO providing services under the Contract from owning or having a financial interest in transportation equipment or any Performing Provider or Material Subcontractor that provides transportation services under this RFP. If it is determined that an MTO selected to provide services under the Contract has such an interest it may be necessary for HHSC to obtain a waiver or state plan amendment from CMS. HHSC's ability to contract with an MTO that has a financial interest may depend on whether CMS grant the waiver.

Without receiving a waiver and/or an amendment to the State Plan, HHSC might still be able to contract with an MTO having a financial interest in the vehicles or Performing Providers, but HHSC may then receive a lower Federal Financial Participation (FFP).
The agency's determination of best value will be determined, in part, by the overall savings resulting from the contract, including a consideration of the amount of federal financial participation (FFP) available to HHSC under the resulting contract. A lower rate of FFP may affect the agency's best value determination. Accordingly, a respondent to the RFP that is not a broker as defined by federal law should demonstrate the ability to achieve additional savings that offset a possible reduced level of FFP and should include detailed explanations of the specific measures the respondent will implement to achieve the additional savings.

This RFP does not require Respondents to propose capitated rates. HHSC will develop and provide capitated rates. These rates will be provided after tentative award of the contract and prior to contract execution

2.3 Nonemergency Medical Transportation Services

HHSC establishes requirements to ensure that interested respondents have the physical capacity, requisite experience, and financial capacity to provide transportation services in accordance with the provisions and requirements set forth in this RFP. The respondents must have significant experience in implementing, managing and providing transportation services similar in scope to the requirements set forth in this RFP. This solicitation requires the delivery of high volume services on a regional basis. (See Attachment C, RFP Data Book).

The following are services that the MTO must provide:

- Demand Response Transportation (see 2.3.1 below)
- Mass Transit Tickets (see 2.3.2 below)
- Individual Transportation Participant (see 2.3.3 below)
- Meals and Lodging (see 2.3.4 below)
- Advanced Funds (see 2.3.5 below)
- Out-of-State Travel (see 2.3.6 below)
- Attendant Services (see 2.3.7 below)
- Commercial Airline Transportation Services (see 2.3.8 below)
- Nonemergency Ambulance Transportation Services (see 2.3.9 below)
- Call Center Operations (see 2.3.10 below)

2.3.1 Demand Response Transportation

Demand response services are contractor provided transportation when fixed route services are either unavailable or do not meet the health care needs of clients. The MTO must describe at a minimum in their response how it will deliver timely demand response services by qualified, courteous, knowledgeable, and trained personnel. The MTO must also describe information relating to requirements that will ensure quality services for pick-up, arrival and departure timeliness; length of time clients will spend in the vehicle during transport; quality of the service; and drivers and types of vehicles. Additionally, the MTO must describe at a minimum how it will remind clients about their pick-up time and their timelines for picking up clients.

2.3.2 Mass Transit Tickets

Mass transit is public transportation by intra-city, inter-city bus, rail, ferry, either publicly or privately owned, which provides general or special service transportation to the public on a regular and continuing basis. The MTO must determine that mass transit is the appropriate mode of transportation for the client. The MTO must ensure that clients do not live more than a quarter mile (¼) mile from a public fixed route stop. Additionally, the MTO must ensure that mass transit tickets are received by the client before the client's appointment.

2.3.3 Individual Transportation Participant (ITP)

Individual Transportation Participant (ITP) services are provided by individuals who volunteer to participate by entering into a participation agreement with HHSC's Claims Administrator. This service allows the flexibility for individuals to transport clients in personal cars to health care appointments. The MTO will be responsible for reimbursing individuals for mileage at the HHSC established rate if a program-eligible client is driven to a health care appointment in a personal car. The MTO must establish and describe in their response how it will implement ITP services for enrolled ITPs in the MTO region in which they provide transportation services, including the qualifications needed for the safe transport of clients in accordance with state and federal laws.

2.3.4 Meals and Lodging

Meal allowance is a means to provide meals for a client and attendant when health care treatment requires an overnight stay outside county of residence or beyond adjacent counties. The MTO must provide the client and attendant (regardless of age) an allowance of $25 per day per person.

Lodging services are facilities, i.e. hotels, made available to clients when their health care treatment requires an overnight stay outside county of residence or beyond adjacent counties for the client and attendant. The MTO is responsible for making the appropriate arrangements, reservations, and coordination with a lodging facility for the client and required attendant(s). Clients and attendant(s) must receive the same quality of services provided to other guests of the establishment. The lodging facility must not bill the client for covered services. Additionally, the MTO must ensure that clients stay at lodging facilities that are equivalent or better than the hotels listed in the Office of the Texas Comptroller's State Travel Management Program.

2.3.5 Advanced Funds

Advanced Funds are funds that are made available to clients facing financial hardship and in need of transportation services to attend a health care appointment. In its response to this RFP, the MTO must provide policies and procedures that demonstrate that the MTO is able to ensure that advanced funds will be disbursed to clients before the appointment date. These funds must be available to eligible clients through age twenty (20); CSHCN clients twenty-one (21) and over who have been diagnosed with cystic fibrosis; and meet the requirements of all applicable laws. Advanced funds must be provided to eligible clients for necessary transportation services when the client requires funds in advance to secure necessary medical and health care services. Advanced funds must, at a minimum cover meals, lodging, and mileage reimbursement for eligible clients.

Currently advanced funds processing includes the following:

- Creating, processing and distributing of funds;
- Disbursing of funds for pickup by a client or an authorized individual at a statewide network of locations such as grocery stores and banks; and
- Establishing control mechanisms to ensure accountability for the accurate and efficient processing of payments.

The MTO may propose other methods for ensuring advanced funds services are available to clients.

2.3.6 Out-of-State Travel

2.3.6.1 The MTO must permit and provide transport to contiguous counties or bordering counties in adjoining states (Louisiana, Arkansas, Oklahoma, and New Mexico) that are within 50 miles of the Texas border, if the services are medically necessary and it is the customary or general practice of clients in a particular locality within Texas to obtain services from the out-of-state provider.

2.3.6.2 Clients may need to travel to states outside of the adjoining states for medically necessary medical care or other health care services that cannot be provided within the state of Texas. The MTO is responsible for arranging and paying for out-of-state travel without additional charge to the client or HHSC.

2.3.6.3 Out-of-state nonemergency transportation services for Medicaid Fee-for-Service clients require prior authorizations from HHSC Office of the Medical Director and the Claims Administrator. The Medical Review Team (MRT) performs a cursory review of the out-of-state referral and communicates directly with the referring physician, if additional information is needed to support the out-of-state referral.

2.3.6.4 The MTO shall refer the requests to the Medical Transportation Program when requesting out-of-state nonemergency medical transportation services for Medicaid Fee-for-Service clients. HHSC will communicate the outcome of the request to the client's MTO via the approved communication protocols. All requests must comply with Texas Administrative Code, Title 1, Part 15, Subchapter B, Rule §380.205(2).

2.3.7 Attendant Services

As a part of their project work plan, the MTO must describe how it will determine when an attendant is necessary for transportation.

2.3.7.1 The MTO is responsible for transporting an attendant for a client when necessary. An attendant is an adult or service animal that accompanies a prior authorized MTP client to provide necessary mobility, personal or language assistance to the client during the time transportation services are provided

2.3.7.2 A client 14 years of age and under must be accompanied by a parent, guardian, or other authorized adult to accompany the client on all trips (See Attachment D, Parental Accompaniment Form).

2.3.7.3 Clients 15 to 17 years of age must be accompanied by a parent, guardian, or other authorized adult unless (i) parent or legal guardian has provided a signed written consent for the client to travel alone or (ii) the treatment to which the minor is being transported is such that the law extends confidentiality to the minor for the treatment.

2.3.8 Commercial Airline Transportation Services

2.3.8.1 Services provided by a commercial airline for transportation to a medical necessary medical care or other health care service that cannot be provided within the MTO region where client resides. The MTO is responsible for arranging commercial air transportation to meet the client's needs for the client and attendant, when applicable (i.e. out of state, out of client's resident MTO region,). The MTO must determine if the medical care or other health care services have been prior authorized and justification for air travel is documented in the client file.

2.3.8.2 Clients needing in-flight oxygen must present a physician script and make arrangements with the MTO no later than five (5) business days before the scheduled flight date. The MTO must ensure that all arrangements for a client needing in-flight oxygen are made before appointment date and time.

2.3.8.3 The MTO must choose a flight that would reduce the number of transfers, travel time, departure and arrival times based on the medical needs of the client and attendant.

2.3.9 Nonemergency Ambulance Transportation Services

Transportation provided by ambulance in a nonemergency situation when all other means of transportation are not suitable for transporting the client to a covered medical care or other health care service.

2.3.9.1 The MTO is required to provide a driver and assistant when using this mode of service.

2.3.9.2 Nonemergency ambulance transportation does not include any medical monitoring, medical aid, medical care, or medical treatment during transport. No flashing lights, sirens, or emergency equipment is required.

2.3.9.3 Nonemergency ambulance transportation includes transportation of clients who are in excess of 600 pounds, need to be transported via stretcher, reclining position, non-ambulatory and need the assistance of at least two persons in order to be transported to and from the vehicle and health care provider or cannot be transported in a taxicab or wheelchair van.

- Needs routine transportation to or from a nonemergency medical appointment or service;
- Is convalescent or otherwise non-ambulatory and cannot use a wheelchair; and
- Does not require medical monitoring, medical aid, medical care, or medical treatment during transport. Self-administered oxygen is permitted as long as the oxygen tank is secured safely.

2.3.10 Call Center Operations

Call center telecommunications systems will be provided by HHSC through a hosted telephony solution (i.e., cloud vendor) for routing calls to the MTO call centers and will include equipment, cabling and telephone sets (see Section 2.27.11). The hosted solution will provide access to historical and real time ACD reports, ACD routing, call recording and call evaluation tools. Vendors will access these through a vendor provided Internet connection. All NEMT calls for scheduling will be made to a single toll-free number. Calls will be routed to specific MTOs based on language, zip code and Medicaid number input into an Interactive Voice Response (IVR) system residing in the vendor cloud.

2.3.10.1 The MTO must operate a call center to manage trip scheduling and authorizations for MTP eligible clients during, at a minimum, primary business hours of 8:00 a.m. to 5:00 p.m. for clients in Central Standard Time Zone and 8:00 a.m. to 5:00 p.m. for clients in Mountain Time Zone, Monday through Friday. A call center may be established within a region that serves one or more MTO regions.

2.3.10.2 A Call Center Operational Procedures Manual that details all procedures used in trip scheduling, authorization of services, and management of transportation services shall be submitted to HHSC for approval prior to the contract start date. HHSC may require modification of the manual at any time, and advise the MTO accordingly. The MTO shall make the manual available to all call center employees and provide training for staff during staff orientation, as content changes occur and/or when new staff is hired.

2.3.10.3 The MTO must have sufficient staff to manage MTP eligible client requests for transportation services to an allowable medical care appointment or other health care services.

2.3.10.4 No call center staff may be stationed at home while performing call center duties.

2.3.10.5 The MTO shall have bilingual employees to assist clients whose primary spoken language is not English. The MTO may contract with an over the phone translation service to ensure that all languages are available for clients.

2.3.10.6 A toll free number for transportation services will be provided by HHSC. All transportation service requests made via telephone must be on this HHSC provided number. The MTO may have additional toll free numbers for purposes other than transportation services. All standards and reports in this RFP apply solely to the toll free number for transportation services.

2.3.10.7 The MTO shall have the staffing capacity to handle all telephone calls at all times during the hours of operation; and have the ability to upgrade for handling additional call volume. This includes adequate incoming phone lines to ensure a monthly average of less than 2% blockage.

2.3.10.8 Call center services must be fully compliant with the Americans with Disabilities Act (ADA), the Health Insurance Portability and Accountability Act (HIPAA) and all other state and federal regulations.

2.3.10.9 The MTO shall prepare an informative announcement message to advise clients of holiday closures, policy changes, etc. Additional educational messages may be provided to callers while they are on hold. These messages require prior approval by HHSC. Once approved, these messages will be scheduled for implementation in the cloud system.

2.3.10.10 The MTO cannot use recording devices as the final point of destination for callers during business hours.

2.3.10.11 The MTO is required to meet or exceed the following call center performance standards.

Metric	**Eligible Clients Through age 20**	**Eligible Clients over age 20**
Average speed to answer (same as average wait in queue)	60 seconds	180 seconds
Percentage of abandoned calls; monthly	10%	12%
Average Maximum monthly wait[1]	300 seconds	900 seconds
Review and score agent calls (per agent,	4%	2%

[1] The maximum monthly average includes all time spent to get to a live person from entry into the MTO phone system to include time spent in an Interactive Voice Response (IVR) or phone tree. The maximum average is computed by adding the maximum waits in queue for each working day of the month and dividing by the number of work days.

monthly)		
Average agent monitoring score (per agent monthly)	87%	85%

2.3.10.12 The MTO call centers must be in the State of Texas and all calls must be answered in the State of Texas.

2.3.11 Call Center Training Requirements

MTO Call Centers shall be staffed sufficiently by well-trained personnel. MTP eligible clients must receive prompt service by a person who is knowledgeable, helpful and polite.

2.3.11.1 Each proposal must include a Training Plan that describes the MTO's proposed training methods, resources the MTO will employ to develop and implement the training, and a proposed development and implementation schedule. The MTO's implementation of the Training Plan will be included in the Readiness Review. Training documents and tests do not need to be submitted with the RFP response. Training materials and all tests need to be submitted, post-award, eight weeks prior to any training of MTO staff or contractors, to allow HHSC adequate time for review and approval.

2.3.11.2 All MTO staff answering calls to the Client Toll-Free Line for transportation services from a caller requesting transportation services must receive thorough training. Initial training will be shared with HHSC prior to implementation; all subsequent changes will be shared with HHSC within five days of implementation. Each MTO is responsible for assuring that all staff are tested on the content of the trainings (initial trainings, plus all subsequent coaching, counseling re-training on both previously trained topics and new topics). The MTO will design these tests to challenge staff understanding and comprehension of MTO training materials.

2.3.11.3 All Call center staff must be given an exam on all training materials. All staff must achieve a minimum exam score of 85%. Staff who achieves a new material exam score below 85% cannot take calls from MTP eligible clients until they successfully achieve a minimum score of 85%.

2.3.11.4 It is not required that all MTO staff meets the 85% on the first try. Individuals failing to meet or exceed that minimum must not answer calls from MTP eligible clients until they are re-tested and able to achieve a score of 85% or better. Exam questions for staff being re-tested must be sufficiently different, to discourage memorization of the previous exam answers.

2.3.11.5 All call center staff must attend re-training shall when call monitoring indicates a need for additional training. Staff whose call monitoring reflects the need for re-training must be re-tested and achieve a minimum score of 85%.

2.3.11.6 All MTO staff shall be trained on scheduling services for a caller requesting transportation services. Training must include use of the call center equipment. Training must also cover all aspects of staff behavior that could impact a caller requesting transportation services (e.g., relevant HIPAA training, phone etiquette, etc.).

2.3.12 Call Center Call Monitoring

2.3.12.1 The MTO must monitor and evaluate 2% of calls from MTP eligible clients. No more than 2% of calls must be "answered" by busy signals, disconnections, or other technical problems that prevent the caller from receiving help from staff for callers other than from or on behalf of a child birth through age 20 with Medicaid (see Section 2.39 below for interpretation of standard).

2.3.12.2 The MTO must submit monitoring evaluation forms, scoring and monthly quality activity reports that fully address all components in this Section and Sections 2.3.10 and 2.3.11.

2.3.13 Call Center Reports

2.3.13.1 The MTO should describe existing or planned call center operations and how it intends to meet the *Frew* standards. The report shall include at a minimum:

- Number of calls received, answered and abandoned;
- Average speed of answer;
- Average wait before abandonment;
- Average hold time (time spent on hold, after agent answers);
- Any after call work or post-call processing (if used); and
- Maximum wait in queue.

2.4 Additional Toll Free Line

The MTO must operate and maintain an additional toll-free number. This line will be used for clients to request a return ride, notify the MTO if client's ride is more than 15 minutes late and for non-client issues (either Performing Providers or HHSC). Calls to this toll-free line from clients requesting a return ride, or to report late pick-ups (more than 15 minutes late) must be answered by live operators continuously Monday through Friday, from 8 a.m. to 5 p.m., Central Standard and Mountain Time Zones. Outbound caller ID for this toll free line must be capable of being dialed (but different from the Client Toll Free Line for transportation services).

2.5 MTO General Operational Requirements

As a part of the business proposal response, the MTO must demonstrate that it meets all requirements and that it has the experience and resources and/or access to such resources and financial capacity necessary to perform the contract required duties. The MTO must describe in the response how it will meet the requirements set forth in this solicitation. The MTO's response shall include a detailed description of its proposed solution to support transportation services and fulfill the requirements stipulated below.

2.5.1 Administrative Office

2.5.1.1 The MTO shall establish and maintain a physical business office within the State of Texas throughout the contract period. If an MTO is awarded more than one region, one (1) central business office may be established in Texas for all regions served.

2.5.1.2 Business hours must be established to ensure coverage of both time zones in Texas, Central Standard and Mountain. Specifically, the hours of operation shall be 8:00 a.m. to 5:00 p.m., Monday through Friday.

2.5.1.3 The MTO's business office and call center operations can only be closed on the following holidays: Thanksgiving Day, Christmas Day and New Year's Day.

2.5.1.4 The MTO may maintain satellite offices in areas of the state that are outside the administrative offices.

2.5.1.5 The MTO shall provide HHSC with an administrative phone number that will enable HHSC staff to contact personnel without having to go through the call center. Emergency contact numbers for key personnel shall be provided to HHSC. In case of an emergency, the MTO shall ensure that a person will be available to answer the administrative phone number to respond to inquiries 24 hours a day (7 days per week).

2.5.2 Key Personnel Skills and Qualifications

2.5.2.1 Recruit and maintain an adequate number of qualified staff to assist with the delivery of transportation services.

2.5.2.2 Ensure that staff and all persons assigned to perform tasks described in this RFP are employees or authorized Performing Providers and have the requisite experience and expertise in accordance with the provisions and requirements set forth in this RFP.

2.5.2.3 As part of the business proposal, the MTO must clearly describe the positions that will be responsible for ensuring contract requirements are met. The MTO must identify the positions, roles and responsibilities and submit documentation clearly outlining the skills and qualifications of key personnel assigned

to undertake each phase of the proposed project. The MTO shall submit a detailed staffing plan that will meet requirements of this RFP and identifies key personnel and their relevant experience. Key staff is considered full-time. Resumes for the individuals selected to fill these positions shall be included in the MTO's response.

2.5.2.4 The MTO must obtain HHSC approval to employ and replace key personnel. The MTO must submit three letters of reference from three different sources for each proposed key employee if employed for less than two (2) years. The letters of references must be from entities that employed the positions, and must describe the transportation contract experience and how the employee is qualified to perform the services. The MTO agrees that the key personnel must not begin work without prior written approval from HHSC. Examples of required positions are noted below:

2.5.2.4.1 The Project Director shall have overall responsibility for the administration and implementation of contract requirements. This individual shall have the authority to make decisions and resolve issues on behalf of the MTO.

2.5.2.4.2 The Project Manager shall assist the project director by ensuring day-to-day implementation of the program and responsible for the transition from implementation to program operation.

2.5.2.4.3 The Automation Coordinator shall principally be responsible for all technical aspects of program operations to include systems interface and automation security. This person acts as the single point of contact for all software users regarding operational status of equipment, application software questions and troubleshooting including in-house help desk operations.

2.5.2.4.4 The Claims Processing Coordinator shall oversee and ensure proper preparation, validation and submission of claims to HHSC for payment.

2.5.2.4.5 Training Coordinator is responsible for developing a written training plan, curricula development, scheduling and ensuring staff are trained and documents and maintains staff training plans for each individual staff member.

2.5.2.5 Designate key personnel to attend mandatory training in Fraud and Abuse detection, prevention and reporting (See Attachment E, Training Requirements).

2.5.2.6 Notify HHSC at least five (5) business days in advance of changing key staff and shall submit justification, including proposed replacements to allow HHSC time to properly review the potential candidate's skills and qualifications and the impact of the change on the delivery of service and contract requirements.

2.5.2.7 Maintain sufficient levels of supervisory and support staff with appropriate training and work experience to perform all contract requirements.

2.5.2.8 Ensure that personnel that deliver services are courteous and provide services that are safe, properly insured for the protection of the passenger and HHSC, reliable and on time.

HHSC reserves the right to require the removal or reassignment of any MTO staff or Performing Provider employee that HHSC deems unacceptable for documented non-performance or good-cause. In the event HHSC exercises this right, the MTO shall remove or replace that staff within fourteen (14) days upon receipt of HHSC's written request.

2.5.3 Termination and Replacement of Key Personnel

HHSC recognizes that events beyond the control of the MTO may result in vacant positions. The MTO must notify HHSC in writing within five (5) business days of a position becoming vacant. The key personnel must be replaced within sixty (60) days after a position vacancy, unless extended by HHSC. Replacement personnel must not begin work without prior written acceptance by HHSC.

HHSC reserves the right to review key personnel resumes for acceptance and may reject the replacement if references or past work performance is questionable or unfavorable. If the MTO or HHSC determines that the key personnel member is unable to perform in accordance with the contract or if the key personnel are unable to communicate effectively, the MTO must immediately remove that staff. The replacement must meet the requirements of this RFP and be provided at no additional cost to HHSC. A resume and references must be available for the replacement staff.

2.5.4 Communication Plan

The MTO is responsible for the design and delivery of a communications plan for the clients residing in the MTO's service region. The purpose of the communications plan is to ensure that clients become aware of the MTO’s services and understand how to use them fully.

In the project work plan, the MTO is required to describe how it will design written communications materials (at a minimum) and other means of communications as the

respondent deems appropriate, in a manner that is reasonably interesting (i.e., contains language, artwork and/or colors, that are engaging enough to hold the client's attention) and sensitive to clients' cultural backgrounds (i.e., considers the context of a client's linguistic, gender, ethnic or geographic experience). This description must address how the respondent will communicate with special populations, including children of migrant workers and emancipated teens.

The MTO is required to describe how it will deliver its communications plan. This description must address how the respondent will cooperate and coordinate efforts with all HHSC agencies which serve transportation clients and others who serve clients, such as case managers, providers, non-state agencies and others that HHSC would direct.

2.5.5 Website

The MTO shall provide and maintain an internet website for clients and the network transportation Performing Providers to access information pertaining to transportation services. The MTO will periodically review the website to ensure the information is up-to-date. At a minimum, the website must contain the following:

2.5.5.1 Website design and content shall be presented in English and Spanish in an accessible manner and submitted to HHSC for approval prior to uploading.

2.5.5.2 Information about the MTO:

- Administrative office address, phone and fax numbers.
- Directions to the MTOs administrative business office.
- Office hours.
- Information regarding the MTO's transportation network
- Statistical information.
- Other information presented by the MTO for HHSC approval.

2.5.5.3 Information for the client:

- Description of transportation services provided and how to access.
- How to file inquiries, complaints, grievances, and appeals.
- Call center information including phone number, hours of operation, trip scheduling.
- Client responsibilities including conduct.
- Other information presented by the MTO for HHSC approval.

2.6 Outreach and Informing Marketing Strategies

Develop outreach and informing marketing strategies and protocols to keep MTP clients knowledgeable about program operation and proposed changes prior to implementation of changes.

2.7 MTO Functional Requirements

2.7.1 Administrative

2.7.1.1 Comply with the provisions of Texas Government Code §533.00257 including:

- Using fixed routes when available and appropriate;
- Attempting to contract with medical transportation providers that are considered significant traditional providers as defined by HHSC rule;
- Meeting the minimum quality and efficiency measures of HHSC;
- Operating under a capitated rate system;
- Assuming financial responsibility in a full risk model; and
- Operating call center.

2.7.1.2 Be registered and certified to conduct business in the State of Texas and agrees to continue this status throughout the contract period.

2.7.1.3 Ensure that personnel are courteous and polite.

2.7.1.4 Manage overall day-to-day operations necessary for the delivery of transportation services.

2.7.1.5 Disclose information about ownership and control related to business transactions and information about persons convicted of crimes. The MTO must provide such information on request to the state.

2.7.1.6 Submit all contract required reports as specified in this RFP. (See Attachment J, Contract Required Reports).

2.7.1.7 Coordinate with the existing state and local Community Organization Resources (See Attachment F, Community Organization Resources) and other urban or rural transit providers. At the Readiness Review, the MTO must provide the name of the Significant Traditional Providers (STP) and Faith Based Organizations (FBOs) contacted to participate in the contract.

2.7.1.8 Ensure a client who submits a response to client survey or files a complaint against the MTO or Performing Provider is not retaliated against, in any manner including denial of services.

2.7.1.9 Ensure that child safety seats are used in accordance with state and federal laws.

2.7.1.10 Obtain approval from HHSC for all written materials developed by the MTO prior to dissemination. The MTO must submit to HHSC all policies and procedures, client notices, client letter templates, client education materials, Performing Provider notifications required within 30 days of contract award.

2.7.1.11 Notify HHSC immediately regarding written notice of any action or suit filed and prompt notice of any claim made against the MTO or Performing Provider which may result in litigation related in any way to the contract with HHSC.

2.7.1.12 Provide assurance of its financial capacity and have the financial resources to sustain services for a minimum of ninety (90) days prior to the initial date of payment.

2.7.1.13 Be in compliance with appropriate local, state and federal licensing or certification requirements.

2.7.1.14 Disclose information on ownership and control, information related to business transactions.

2.7.1.15 Implement and maintain a drug and alcohol testing program in accordance with federal regulations 49 C.F.R Part 40 and Part 655. Use of any substance that may impair the operation of the motor vehicle by the driver is prohibited.

2.7.2 Trip Scheduling/Verification

2.7.2.1 Advance scheduling is required for all transportation services. The client must contact the MTO to request transportation services at least two (2) business days prior for services within the MTO region and five (5) business days prior for services beyond the MTO region.

2.7.2.2 Out-of-state, nonemergency trips require a minimum of thirty (30) days for medical review to assess the necessity for out-of-state travel.

2.7.2.3 The MTO shall use a script approved by HHSC to interview the client for the purposes of determining whether the client has an appointment and the means of transportation to the medical appointment. If the client does not have a means to get to the appointment, the MTO is authorized to arrange for transport.

2.7.2.4 The MTO will receive client phone calls and perform intake services that include verification of client's eligibility status and that the destination is to a covered medical care or other health care service, assessment of the most appropriate and cost

effective means of transport, taking into consideration the client's health and medical condition.

2.7.2.5 Call center staff shall verify that the purpose of the trip is to a covered medical care or other health care service. Covered medical care or other health care services and other reference materials will be provided to the MTO awarded a contract.

2.7.2.6 Client eligibility verification will be completed using a monthly and daily data file provided by HHSC. HHSC Information Technology staff will establish a secure file transfer protocol, where daily files will be available to the MTO. In the event the MTO cannot verify the client's eligibility, the MTO shall contact MTP.

2.7.2.7 The MTO shall determine the most appropriate service to transport eligible clients, and must provide transport services using the following categories (See Attachment B, Definitions and Acronyms):

- Demand Response Transportation
  - Hospital discharges
  - Same day services
  - Urgent requests
  - Shared Ride
- Mass Transit Tickets
- Individual Transportation Participant
- Meals and Lodging
- Advanced Funds
- Out-of-State Travel
- Attendant Services
- Commercial Airline Transportation Services
- Nonemergency Ambulance Transportation Services

2.7.2.8 Criteria for determining the appropriateness of the transportation type must be developed by the MTO and submitted as a part of the RFP response. The criterion must be approved by HHSC. Additionally, the MTO must develop procedures for implementing, receiving, and scheduling transportation services including verification of eligibility for services. These items must be included in the MTO's response to the RFP.

2.7.2.9 The MTO is responsible for ensuring availability of transportation services from the client's address to or from covered medical care or other health care service. Transportation services are at no cost to the client.

2.7.2.10 The MTO is not responsible for arranging transportation services for clients who do not reside in their MTO region.

2.7.2.11 The MTO is responsible for arranging travel into and out of other regions when the client being transported is a client who resides in the MTO region.

2.7.2.12 The MTO shall not discriminate against clients requesting transportation services on the basis of health status or need for transportation services, race, ethnicity, color, national origin or religious affiliation and will not use any policy or practice that has the implied intent of discriminating on the basis of race, color, national origin, religious affiliation, or any other legally protected status.

2.7.2.13 Trips may be arranged on a per-trip or recurring basis for no more than thirty (30) days. The MTO shall schedule, group and assign trips individually or as a series of appointments.

2.7.2.14 The MTO and any Performing Providers shall mutually agree upon a method of communicating trip referrals. The MTO shall monitor trips assigned to Performing Providers to ensure they are not overbooked.

2.7.2.15 The MTO shall minimize the waiting and riding times for persons with special needs (e.g., dialysis patients, severely disabled and medically fragile children and seniors) and specify how this will be accomplished and include in the RFP response.

2.7.2.16 The MTO shall use a systematic scheduling system that can accommodate both advance reservations and same day service.

2.7.2.17 In addition to the items listed above, the MTO shall describe in their RFP response, other services, if any, that they will make available for eligible clients to meet their needs.

2.7.3 Trip Authorizations

2.7.3.1 The MTO is responsible for authorizing services for program eligible clients. As a part of the work plan, the MTO must describe how it will develop, document, maintain, and implement a system for verifying eligibility of transportation services and service authorization. HHSC agency rules and MTP policies should be used as guidelines for determining the authorization of the services. The authorization system must be able to accept a secured file with eligibility information from HHSC.

2.7.3.2 The MTO must verify program eligibility for services as part of the authorization process.

2.7.3.3 The MTO must also permit and provide for out-of-state travel.

2.7.3.4 The MTO must establish procedures to handle trip requests so clients are not required to continually make transportation arrangements for repetitive appointments. At a minimum, the procedure must meet the requirements in the current *Frew* corrective action plan (CAP) and ensure validation of client eligibility for the service over the timeframe of the repetitive appointments.

2.7.4 Trip Manifest

2.7.4.1 The MTO shall provide a detailed description of the process that it will follow to distribute trip information to drivers and enrolled Performing Providers to ensure timely and safe transport of clients to an enrolled medical provider. The MTO shall ensure that the information contains:

- A unique identifier for billing purposes.
- Client's name, phone number and the pick-up address.
- Destination address (including the name of the facility and the phone number).
- Mode of transport.
- Client mobility devices or other medical equipment, where applicable. Any special needs or instructions regarding the client, or other passengers.

2.7.4.2 Ensure that clients arrive to health care facilities at least 15 minutes but no more than one (1) hour prior to their scheduled appointment times. No client should be dropped off prior to the health care providers' scheduled operating hours.

2.7.4.3 Schedule trips to ensure that a client does not remain in the vehicle for one hour longer than the average travel time for direct transportation of that client.

2.7.4.4 Ensure clients are only transported to the destination as authorized on the trip manifest.

2.7.4.5 Ensure that MTOs and Performing Providers have dispatch communication systems to remain in continuous contact with drivers to control and monitor service delivery.

2.7.4.6 Ensure that MTOs and Performing Providers dispatch back-up vehicles and drivers when the transportation service delivery standard cannot be met.

2.7.4.7 Ensure that MTO and subcontract staff identifies themselves as a MTO agent when communicating with clients or health care providers about authorized trips.

2.7.4.8 Ensure clients are contacted one business day prior to the scheduled ride to confirm client pickup location, destination, date, and time, when a contact number is listed on the manifest. Calls should not be made after 9:00 p.m.

2.7.4.9 Keep logs documenting the date, time and telephone number for each call made to clients the day before the appointment.

2.7.4.10 Remind client's parents and attendants about the requirements for child safety seats as referenced in Texas Transportation Code §545.412. The MTO must ensure child safety seats are provided by client's parent or guardian, or authorized attendant in accordance with State and Federal law. Further, the MTO must advise persons accompanying children at the time of trip scheduling notification that car safety seats are required.

2.7.4.11 Require Performing Providers to notify the MTO the next business day if the client's contact number(s) are disconnected or incorrect as listed on the trip manifest.

2.7.4.12 Require the MTO and Performing Providers to document all cancellations, no shows and rescheduled trips.

2.7.4.13 Have a method or process to inform clients that their ride has arrived at the pick -up location and ensure the driver waits ten minutes before leaving and declaring the trip a no show. This process must be submitted to HHSC for approval.

2.7.4.14 Notify the Performing Provider to ensure that pick up occurs within three (3) hours after notification of a hospital discharge; and

2.7.4.15 Communicate with drivers when clients are having difficulty with scheduling or dispatching.

2.7.5 Pick-up and Delivery Requirements

The MTO must ensure that transportation dispatch services, for pick-up and delivery, are available 8:00 a.m. to 5:00 p.m. for clients in Central Standard Time Zone and 8:00 a.m. to 5:00 p.m. for clients in Mountain Time Zone, Monday through Saturday. Services must comply with the following minimum service requirements.

2.7.5.1 The MTO is responsible for confirming scheduled trips with clients twenty-four (24) hours prior to the pick-up date and time.

2.7.5.2 The MTO and Performing Providers must wear or have visible, easily readable proper company identification.

2.7.5.3 The MTO is required to wait no more than ten (10) minutes after the scheduled pick-up time.

2.7.5.4 The MTO is required to pick-up a client from an appointment within one (1) hour from time of notification.

2.7.5.5 Drivers shall notify the MTO's transportation dispatcher immediately of late arrivals so contact can be made with the medical service provider to advise of the late arrival.

2.7.5.6 HHSC requires client and attendant signature as a means to verify and validate that transportation was provided. A digital signature is acceptable as long as the MTO is able to store and retain the signatures in compliance with Section 2.41 (*Frew* Record Keeping and Record Retention) and make available to HHSC upon request.

2.7.5.7 The MTO and Performing Providers must obtain client and attendant signature for documentation of provision of each segment of a trip on the driver logs.

2.7.5.8 Drivers may only obtain the client's signature at the time the service is provided.

2.7.5.9 Inability to obtain a client or attendant's signature must be documented. Service must not be denied to the client or their attendant on the basis of refusal to sign. A client or attendant may place a mark on the driver log in place of their signature when they are unable to sign. The driver or attendant must sign beneath the mark as the witness.

2.7.5.10 The driver log, at a minimum, must contain the following data elements:

- Performing Provider
- Date of service
- Driver's first name
- Driver's last name
- Driver's License Number
- Driver's signature
- Vehicle identification number and vehicle number, if any
- Unique trip authorization number for each segment
- Type of vehicle authorized, if specialty vehicle
- Pick up time
- Pick up address
- Drop off time
- Drop off address
- Miles driven per trip odometer
- Status of trips (e.g., cancellation, no show, accident or incident)
- Client's first and last name
- Attendant's first and last name
- Client's signature and attendant's signature

In lieu of a driver log, the MTO or its Performing Provider may use an automated system, to capture and report the data elements specified above. The identified system should be included in the response.

2.7.5.11 Drivers should not use mobile devices while the vehicle is in motion.

2.7.5.12 Provide assistance according to the clients' needs, but assistance shall not include the lifting of any client, except when nonemergency ambulance transportation is the mode of travel.

2.7.5.13 At no time, should drivers, clients, passengers or attendants smoke while in or in proximity (15 feet) of the vehicle.

2.7.5.14 The MTO and Performing Provider must exhibit proper behavior at all times and must not engage in horseplay, inappropriate conversations or arguments with clients.

2.7.5.15 Perform equipment safety checks prior to vehicle departure.

2.7.6 Inquiries, Complaints, Grievances and Appeal

The MTO must describe in their project work plan the policies and procedures and detail the process to manage inquiries, complaints, grievances, and appeals. At a minimum the MTO must:

2.7.6.1 Develop educational information to inform clients of available avenues to voice their complaints, including but not limited to:

- MTP complaint center; and
- HHSC Office of the Ombudsman.

2.7.6.2 Develop a system for receiving, retaining, managing, resolving, and reporting client inquiries, complaints, grievances and appeals to HHSC.

2.7.6.3 Ensure that the inquiries, complaints, grievances, and appeals data contains details regarding the nature of the issue, the process to resolve the issue and final determination. This information should be made available to HHSC upon request.

2.7.6.4 Ensure that inquiries, complaints, grievances, and appeals inquiries are responded to within a predetermined timeframes (See Attachment S, MTO Key Performance Requirements).

2.7.6.5 The MTO agrees that it will not interfere with or contact a client when the client sends an inquiry, complaint, grievance, appeal or client survey directly to HHSC.

2.7.7 Service Denial

Upon review and approval by HHSC of the MTO's determination procedure, the MTO may deny service requests if the request is not a benefit of the funding program and does not meet the terms of this RFP. Additionally, the MTO must develop policies to address excessive no shows and other unacceptable client behavior. The policies must be submitted in the MTO's response to the RFP in the project work plan. All policies must be submitted to HHSC for prior approval and must be provided in writing to all clients at the time of transportation request or at least thirty (30) days before a change is effective.

If a request for transportation services falls under one or more of the denial criteria listed below, the MTO shall deny the request and enter the reasons for the denial in the database, similar to scheduling a trip. Within 24 hours of denial of service, the MTO shall generate and mail denial letters to clients. The letter must stipulate the client's right to appeal the denial. HHSC must review the proposed letter prior to implementation and reserves the right to edit the document. Denial criteria may include but is not limited to the following reasons:

- The client is not eligible for transportation services on the date of service request.
- The client refuses to cooperate in determining status of eligibility.
- The client does not provide additional documentation in a timely manner.
- There is not a medical need that requires transportation service.
- Other transportation means are available to the client.
- Transportation requested is not to a covered service.
- The client does not accept the most cost efficient method of transportation services offered.

Prior to the denial of service, the MTO shall notify the client in accordance with Texas Administrative Code, Title 1, Part 15, Chapter 357, Subchapter A relating to Uniform Fair Hearing Rules. A client whose services have been denied may request an administrative review by the MTO's management, an administrative review by HHSC, or request a fair hearing. A request for a fair hearing must be in writing and mailed. MTO's awarded a contract under this RFP will be provided with additional instructions.

2.7.8 Internal Reviews, Administrative Reviews and Fair Hearings

An Internal Review, a Medical Transportation Administrative Review, and a Fair Hearing are three separate events.

2.7.8.1 An Internal Review is conducted by the MTO in an attempt to explain or resolve a complaint from a client relating to the denial, reduction or delay of a transportation service for which that client is, or believes to be, eligible.

2.7.8.2 A Medical Transportation Administrative Review is conducted by MTP in an attempt to explain or resolve a complaint from a client relating to an MTO's denial, reduction or delay of providing transportation service for a client.

2.7.8.3 A Fair Hearing is heard by an impartial HHSC Hearings Officer where the MTO must represent the case for HHSC. Nearly all Fair Hearings are conducted over the telephone.

2.7.9 MTO Responsibilities

2.7.9.1 The MTO must provide effective and understandable notice to all clients that the client has the right to a timely Internal Review by the MTO, a Medical Transportation Administrative Review by MTP and/or to a Fair Hearing before an impartial hearings officer of HHSC if a transportation benefit to which the client is or believes they are entitled to is denied, reduced or delayed.

2.7.9.2 If the client requests a Fair Hearing, the MTO must effectively represent the case for the denial, reduction or delay at the scheduled Fair Hearing. Failure to do so will result in penalties or Liquidated Damages.

2.7.9.3 The MTO must follow the rules regarding hearings and notice of adverse actions in Texas Administrative Code, Title 1, Part 15, Chapter 357 and any other relevant federal and state rules and policies.

2.7.9.4 Failure to carry out the required procedures regarding notice of adverse actions; representation at the fair hearing; the continuation of benefits to those eligible; the prompt implementation of hearing decisions; to provide a full record of requested files to the client, MTP or the hearing officer; or any other responsibilities regarding the hearings process may result in penalties or liquidated damages.

2.7.9.5 The right to an appeal from an HHSC hearing officer must be provided to client in writing and through oral interpretive services. A written description of the fair hearing procedures must be available in prevalent non-English languages identified by HHSC, at no more than a 6th grade reading level. The MTO must include a written description of the fair hearings process in the RFP response. The MTO must provide oral interpretive services to callers free of charge.

2.7.9.6 The MTO must ensure designated staff is available to assist clients in understanding and using the fair hearing process. The MTO must provide the client with a written notice for the client to request a fair hearing. The notice must contain a mailing address and fax number for the client to submit the request.

2.7.9.7 The MTO must notify HHSC MTP within 24 hours of a request for a fair hearing, by secured e-mail or fax.

2.7.9.8 If the request for a fair hearing is made within ten (10) days of the date the client is informed by the MTO that it intends to

deny, reduce or delay benefits, the MTO must continue to provide the disputed benefit until a decision is made by the hearing officer.

2.8 Transportation Network

2.8.1 Overview

2.8.1.1 The MTO will be responsible for establishing and maintaining an adequate transportation network to meet transportation services needs for clients eligible to receive services within the MTO region (See Attachment C, RFP Data Book).

2.8.1.2 In order to determine network adequacy, the MTO shall consider the following:

- Eligible clients in the MTO region:
- Historical information based on the types of services received by clients in the MTO region.
- Geographic location of providers and clients, including distance, travel time and typical transportation mode previously used.

2.8.1.3 The MTO must maintain records on each Performing Provider that the MTO has contracted with to provide transportation services. At a minimum, documents that the MTO shall maintain and have available for HHSC review shall include:

2.8.1.3.1 A signed copy of the MTO's executed contract with each Performing Provider.

2.8.1.3.2 Vehicle documentation and maintenance records to ensure that the vehicles used to provide the service meet all vehicle standards requirements.

2.8.1.3.3 Driver records that establish full compliance with all vehicle operators' standards for each Performing Provider.

2.8.1.4 The transportation network will be comprised of various modes which are described in detail below:

- Ambulance: vehicle capable of transporting nonambulatory, bariatric or stretcher clients.

- Buses: a multiple passenger vehicle. Buses can also be micro or mini.

- Sedans: a four door, five passenger vehicle.

- Special need transportation must use vehicles that meet the Americans with Disabilities Act specifications and requirements.

- Wheelchair Van: a van equipped with lifts and locking devices to safe secure a wheelchair while the van is in motion. Each wheelchair vehicle shall have, for each wheelchair position, a wheelchair securement device (or "tie down") which meets current ADA guidelines.

- Van: full size vans or mini vans.

2.9 General Vehicle Requirements

2.9.1 Rule Requirements

The MTO must have vehicles that comply with all applicable state and federal laws, including the Americans with Disabilities Act (ADA) Accessibility Guidelines for Transportation Vehicles (36 C.F.R. Part 1192), Federal Motor Vehicle Safety Standards (49 C.F.R. Part 571), and Texas Transportation Code, Title 7, Chapter 547.

2.9.1.1 MTO and Performing Provider must ensure the availability of a sufficient number of Performing Providers with a reliable fleet of vehicles, including ADA compliant vehicles, available to meet the specified transportation service requests, and service requirements for all clients in the region.

2.9.1.2 MTO and Performing Provider must ensure all Performing Provider vehicles are properly maintained and communication systems, and other equipment required in connection with operation of transportation services are in good working condition.

2.9.1.3 MTO and Performing Provider must ensure that equipment is maintained in operable condition at all times and in accordance with manufacturer's recommended maintenance procedures as well as with applicable federal and state regulations.

2.9.1.4 MTO and Performing Provider must ensure that Special Needs Vehicles must comply with all applicable Federal laws including the Americans with Disabilities Act (ADA) regulations. Any vehicle found to be not in compliance with State of Texas licensing requirements, safety standards, ADA regulations, this RFP requirements, or any other State or Federal law or regulation, must be removed from service immediately.

2.9.1.5 MTO and Performing Provider must ensure all precautions are taken to ensure client safety. The MTO bears all risk associated with client safety and will ensure vehicles and signage are

adequate to inform clients of applicable safety precautions and standard they will be required to follow in accordance with all applicable state and federal laws.

2.9.1.6 If HHSC identifies insufficient transportation resources in the MTO region, HHSC will notify the MTO and the MTO shall have ten (10) business days after the date of such notice in which to develop and implement a plan to recruit sufficient Performing Providers to meet the transportation needs of the clients in the MTO region. If the MTO identifies an area of the state with insufficient transportation resources, the MTO shall immediately notify HHSC and shall have ten (10) business days in which to recruit sufficient Performing Providers to meet the transportation needs of the clients in the MTO region.

2.9.1.7 Temporary vehicles may only be used for a maximum of three (3) months and must be listed on the Vehicle Roster Report and specified as such. Temporary vehicles may use magnetic signs and must meet all vehicle requirements. Vehicles must be available for inspection at any time.

2.9.1.8 Vehicles must pass the state of Texas annual inspection and receive and pass a semi-annual Performing provider inspection by the MTO.

2.9.2 Vehicle Standards

Vehicles must meet minimum standards regarding the physical condition and maintenance of motor vehicles used to provide transportation services as defined in Texas Administrative Code, Title 1, Part 15, Chapter 380, Subchapter E, Rule §380.501. All motor vehicles used to provide transportation services must:

2.9.2.1 Meet or exceed warranty and component standards for both state and federal safety mechanical operating and maintenance standards.

2.9.2.2 Be identified with the transportation provider name and vehicle number using letters that are at a minimum six (6) inches in height; and

2.9.2.3 Be equipped with:

2.9.2.3.1 Functioning, clean, and accessible seat belts for each passenger seat position that must be stored off the floor when not in use.

2.9.2.3.2 An operating speedometer and odometer.

2.9.2.3.3 Working interior lights within the passenger compartment.

2.9.2.3.4 Adequate interior sidewall padding and ceiling covering.

2.9.2.3.5 Two exterior rear view mirrors, one on each side of the vehicle.

2.9.2.3.6 An interior mirror, which should be used for monitoring the passenger compartment.

2.9.2.3.7 A clean interior and exterior (which must be free of broken mirrors or windows, excessive grime, rust, chipped paint, and major dents).

2.9.2.3.8 A functional fire extinguisher (which must be secured within reach of the motor vehicle operator and visible to passengers).

2.9.2.3.9 A first aid kit (which must include at a minimum latex gloves, hazardous waste disposal bags, scrub brush, disinfectant, and deodorizer).

2.9.2.3.10 Working heating and cooling systems adequate for the heating, cooling and ventilation needs of both the motor vehicle operator and the passengers.

2.9.2.3.11 All windows must be operational.

2.9.3 Vehicle Registration Information

The MTO must establish, maintain, and provide upon request, the following records, and related information in its files, including at a minimum the following documentation for each vehicle:

- Manufacturer and model;
- Model year;
- Vehicle Identification Number and vehicle assigned number, if any;
- Odometer reading at the time the vehicle entered service under the contract;
- Type of vehicle (minibus, wheelchair van or ambulance);
- Capacity (number of passengers);
- License plate number;
- Insurance certifications;
- Texas Department of Motor Vehicles (TxDMV) – issued registration permit and vehicle stamp;
- Special equipment (lift, etc.);
- Description of inspection activity, date and odometer reading (e.g., verification that vehicle meets contract vehicle requirements, inspection of equipment

such as brakes, tire tread, turn signals, horn, seat belts, air conditioning/heating, etc.), and

- History of all vehicle inspections must be kept on file and available for HHSC for review.

2.9.4 Standards for Motor Vehicle Operators

For any motor vehicle operator providing or seeking to provide transportation services through the MTO, the MTO must:

2.9.4.1 Verify that the motor vehicle operator has a valid driver's license. A motor vehicle operator without a valid driver's license may not provide transportation services under the contract.

2.9.4.2 Verify the driving record information of the motor vehicle operator that is maintained by the Department of Public Safety (DPS) pursuant to Texas Transportation Code, Chapter 521, Subchapter C. A motor vehicle operator who does not meet driving history requirements may not provide transportation services.

2.9.4.3 Check the public criminal record information of the motor vehicle operator that is maintained by DPS and made available to the public through the DPS website. A motor vehicle operator who does not meet criminal history requirements as specified in the contract between HHSC and the MTO may not provide transportation services under the contract.

2.9.4.4 Ensure drivers do not have any findings by a law enforcement authority of driving while intoxicated (DWI/DUI) or under the influence of any substance that may impair the driver's ability to safely operate a motor vehicle within seven years prior to the initial hire date or any time after the hire date. Any driver who is convicted of DWI/DUI after the hire date is immediately ineligible to provide services under the contract for a period of seven years after the date of conviction.

2.9.4.5 Ensure drivers do not have a felony or misdemeanor conviction within seven years of the initial hire date or any time after the hire date of:

2.9.4.5.1 an act of abuse, neglect or exploitation of children, the elderly or persons with disabilities as defined in Texas Family Code, as amended, Chapter 261 and Texas Human Resources Code, as amended, Chapter 48; or

2.9.4.5.2 an offense under the Texas Penal Code, as amended, against the person; against the family; against public order or decency; against public health, safety or morals; against property; an offense under

Chapter 481 of the Texas Health and Safety Code, as amended, (Texas Controlled Substances Act); and

2.9.4.5.3 Drivers must not have been found to have conducted or participated in any acts prohibited by the Texas Human Resources Code Chapter 36.

2.9.4.6 The MTO shall conduct or cause to be conducted for each new employee, employee, Performing Provider, Performing provider employee who works directly with clients under the contract, or who have direct access to client records, a state Internet Computerized Criminal History file (CCH) background check through the Department of Public Safety's public internet website, a National CCH from an organization that is nationally approved and recognized to provide criminal history background checks, and a National and State Sex Offender Registry check, which shall be maintained by the MTO, available for review by the HHSC.

2.9.4.7 The MTO must submit the name of the nationally approved and recognized organization it elects to use for the national criminal history and background check to HHSC for approval. The MTO shall check for felony and misdemeanor convictions for the seven (7) years prior to the hire date and annually thereafter. Individuals with any criminal conviction that falls within the aforementioned categories that occurred within seven (7) years prior to the hire date or any time after the hire date shall not be allowed to participate in providing requirements of the contract and any services that are determined to have been provided by a person not eligible to provide services under the contract will be recouped.

2.9.4.8 Drivers must not solicit or accept money, goods or additional business from clients.

2.9.4.9 Drivers must meet federal guidelines for HIPAA compliance by keeping all client protected health information (PHI) confidential.

2.9.4.10 Ensure that all drivers are at least 18 years of age.

2.10 Driver Requirements

2.10.1 MTO and Performing Provider Driver Reports

The MTO shall provide HHSC a listing of Performing Providers providing transportation services on behalf of the MTO and a roster of all drivers before the start of operations. Drivers must be listed separately for each Performing Provider. The roster shall include, at a minimum, the driver's name and driver's license number. The MTO shall submit to HHSC, updated changes that identify additions and deletions in personnel. The roster is due sixty (60) days prior to implementation and quarterly thereafter.

2.10.2 Driver Training

2.10.2.1 All drivers must receive training on the following topics:

- passenger safety (training to occur at least annually);
- passenger assistance (training to occur at least annually);
- assistive devices, including wheelchair lifts, tie-down equipment, and child safety seats (training to occur at least annually);
- non-discrimination, sensitivity, and diversity;
- customer service;
- defensive driving techniques (training to occur at least every two years);
- prohibited behavior by motor vehicle operators, including use of offensive language, use of tobacco, alcohol or drugs, and sexual harassment; and
- any other additional training HHSC determines to be necessary.

2.11 MTO Responsibilities

2.11.1 Client Satisfaction Survey

The MTO must describe in the project work plan how it will ensure client satisfaction regarding MTO operations and delivery of services through contracting with an independent research organization to conduct client and medical service provider satisfaction surveys annually. The survey should include a statistically significant number of clients, Performing Providers, type of service and medical providers, including a statistically significant subset of clients with LEP. The research organization client sample must include services from 25% of the Performing Providers each quarter to ensure that 100% of all Performing Providers are surveyed annually. HHSC must approve the survey prior to implementation. The survey results and analysis of those responses must be submitted to HHSC by the independent research organization directly to HHSC no later than 60 days after the completion of the surveys.

2.11.2 Performing Providers

2.11.2.1 Ensure that all Performing Providers are properly enrolled through the Claims Administrator prior to entering into an agreement with the MTO. (See Attachment G, Other Resources, Attachment H, MTO Disclosures and HHSC Requirements; and Attachment I, Material Subcontractor Screening Requirements)

2.11.2.2 Negotiate fair and equitable reimbursement for services with each qualified Performing Provider. The MTO must attempt to contract with a Performing Provider that agrees to accept the prevailing rate in that MTO region.

2.11.2.3 Ensure that personnel that deliver services are courteous and provide services that are safe, reliable and on time, properly insured for the protection of the passenger and HHSC.

2.11.2.4 The MTO or Performing Provider shall not seek payment or reimbursement from any client for the cost of any transportation services.

2.12 Insurance

The MTO shall ensure that transportation providers have insurance coverage that is consistent with state statutes. Governmental entities are required to comply with state and federal laws applicable to that entity. A governmental entity that provides transportation services and that does not purchase insurance, must provide an affidavit prior to beginning service that indicates how, and the authority under which, the performing governmental entity covers its liability.

2.12.1 Insurance to be Carried by the MTO

2.12.1.1 The MTO must obtain and maintain at least one million dollars ($1,000,000) Commercial General Liability Insurance with HHSC as an additional insured and a waiver of subrogation in favor of HHSC. Insurance coverage must be issued by a company licensed in Texas, with an A rating from A.M. Best and authorized to provide the corresponding coverage.

Commercial General Liability:
Occurrence based:
Bodily Injury and Property Damage
Each occurrence limit: $1,000,000
Aggregate limit: $2,000,000
Medical Expense each person: $5,000
Personal Injury and Advertising Liability: $1,000,000
Products/Completed Operations Aggregate Limit: $2,000,000
Damage to Premises Rented to You: $50,000

2.12.1.2 The MTO must obtain and maintain Workers' Compensation & Employers Liability Insurance in accordance with the State of Texas statutory limits and a waiver of subrogation in favor of HHSC. Insurance coverage must be issued by a company licensed in Texas, with an A rating from A.M. Best and authorized to provide the corresponding coverage.

Workers Compensation: Statutory Limits
Employers Liability: Each Accident $1,000,000
Disease: Each Employee $1,000,000
Disease: Policy Limit $1,000,000

2.12.1.3 The MTO must obtain and maintain at least seven hundred and fifty thousand dollars ($750,000) combined single limit Business Auto Liability for owned, non-owned and hired automobiles in accordance with the State of Texas statutory limits and a waiver of subrogation in favor of HHSC. Insurance coverage must be

issued by a company licensed in Texas, with an A rating from A.M. Best and authorized to provide the corresponding coverage.

CSL (Combined Single Limit): $750,000 bodily injury per person, bodily injury per accident, property damage per accident

2.12.1.4 The MTO must obtain and maintain at least one million dollars ($1,000,000) Identity Theft Coverage.

2.12.1.5 Policies must provide 30 calendar days' notice to HHSC prior to any cancellation or modification of any of the required insurance coverage.

2.12.1.6 Within ten (10) business days following execution of a contract resulting from this RFP, the successful respondent (MTO) must provide HHSC with the required Certificates of Insurance. At any time, upon request by HHSC, and at no additional cost to HHSC, the MTO must provide HHSC with complete copies of all insurance policies applicable to the contract.

Failure to obtain or maintain required insurance will be a material breach of contract.

2.12.2 Insurance to be Carried by Performing Providers

In its proposal the MTO must describe how they will ensure Performing Provider compliance with all applicable federal, state and local laws relating to insurance requirements for all transportation services. HHSC will compare coverage in each response to this RFP for comparative evaluation purposes. Failure by HHSC to object to any or all aspects of the proposed coverage will not relieve the MTO from responsibility to know and assure Performing Provider compliance with all applicable federal, state and local regulations pertaining to insurance for all transportation services.

Transportation services include but may not be limited to those services listed in Section 2.3 of this RFP.

The MTO must not permit a Performing Provider to provide transportation services for clients unless that Performing Provider has current and appropriate insurance. Documentation and proof of insurance must be maintained at the MTO's Texas headquarters. MTO responsibility includes checking and maintaining copies of renewals and any changes, modifications or amendments made to the insurance policies, inclusive of cab companies and individuals. Failure to comply with documentation requirements will result in the assessment of liquidated damages.

If the MTO purchases insurance for Performing Providers, the limits must meet or exceed those required by the appropriate federal, state or local regulatory authority and the insurance must contain a waiver of subrogation in favor of HHSC with HHSC as an additional insured.

2.12.3 Insurance Requirements for ITPs

ITPs must comply with the minimum amount of liability coverage required by the State of Texas**.**

2.13 Workmanship and performance

2.13.1 General Requirements for All Insurance Coverage

2.13.1.1 Except as provided herein, all exceptions to the Contract's insurance requirements must be approved in writing by HHSC.

2.13.1.2 MTO or the Network Provider is responsible for any and all deductibles stated in the insurance policies.

2.13.1.3 Insurance coverage must be issued by insurance companies authorized to conduct business in the State of Texas.

2.13.1.4 With the exception of Professional Liability Insurance maintained by Network Providers, all insurance coverage must name HHSC as an additional insured. In addition, with the exception of Professional Liability Insurance maintained by Network Providers and Business Automobile Liability Insurance, all insurance coverage must name HHSC as a loss payee.

2.13.1.5 Insurance coverage kept by the MTO must be maintained in full force at all times during the Term of the Contract, and until HHSC's final acceptance of all Services and Deliverables. Failure to maintain such insurance coverage will constitute a material breach of the contract.

2.13.1.6 The Parties expressly understand and agree that any insurance coverages and limits furnished by MTO will in no way expand or limit MTO's liabilities and responsibilities specified within the Contract documents or by applicable law.

2.13.1.7 MTO expressly understands and agrees that any insurance maintained by HHSC will apply in excess of and not contribute to insurance provided by MTO under the Contract.

2.13.1.8 If MTO, or its Performing Providers, desire additional coverage, higher limits of liability, or other modifications for its own protection, MTO or its Performing Providers will be responsible for the acquisition and cost of such additional protection. Such additional protection will not be an Allowable Expense under the contract.

2.13.1.9 MTO will require all insurers to waive their rights of subrogation against HHSC for claims arising from or relating to the contract.

2.13.2 Proof of Insurance Coverage

2.13.2.1 The MTO must furnish HHSC the original Certificates of Insurance evidencing the required insurance coverage on or before the Effective Date of the Contract. If insurance coverage is renewed during the Term of the Contract, the MTO must furnish HHSC the renewal certificates of insurance, or such similar evidence, within five (5) Business Days of renewal. The failure of HHSC to obtain such evidence from MTO will not be deemed to be a waiver by HHSC and MTO will remain under continuing obligation to maintain and provide proof of insurance coverage.

2.13.2.2 The MTO is not required to furnish HHSC with proof of Professional Liability Insurance maintained by Performing Providers on or before the Effective Date of the Contract, but must provide such information upon HHSC's request during the Term of the Contract.

2.13.3 Performance Bond

The MTO must obtain a performance bond with a one (1) year term. The performance bond must be renewable and renewal must occur no later than the first day of each subsequent State Fiscal Year. The performance bond must continue to be in effect for one (1) year following the expiration of the final renewal period. MTO must obtain and maintain the performance bonds in the form prescribed by HHSC and approved by TDI, naming HHSC as Oblige, securing MTO's faithful performance of the terms and conditions of the contract. The performance bonds must comply with Chapter 843 of the Texas Insurance Code and 28 T.A.C. §11.1805. At least one (1) performance bond must be issued. The amount of the performance bond(s) should total $500,000.00 (five hundred thousand dollars) for each Region that the MTO covers. Performance bonds must be issued by a surety licensed by TDI, and specify cash payment as the sole remedy. MTO must deliver each renewal prior to the first day of the State Fiscal Year.

In order to terminate the Agreement pursuant to this Section, MTO must give HHSC at least one-hundred twenty (120) days written notice of intent to terminate. The termination date will be calculated as the last day of the month following one-hundred twenty (120) days from the date the notice of intent to terminate is received by HHSC.

2.14 Accidents/Incidents

The MTO shall report any accidents, injuries and incidents on a prescribed HHSC form within the prescribed time frames noted below:

- Accident/incident with injury - notification within 1 hour
- Accident/incident without injury - within 24 hours

In the event of an accident or injury, the MTO shall develop a trip recovery protocol to ensure that clients arrive at their appointment on time and are transported to their residence without excessive delays.

2.15 Hazardous Weather

The MTO shall include in its Operations Manual, a written plan that describes how the MTO will communicate with clients, providers and HHSC MTP regarding trip cancellations or delays due to hazardous weather conditions.

2.16 Applicable Laws

In addition to the requirements of the HHSC Uniform Contract Terms and Conditions (UTCs), the MTO must comply with all applicable laws, including but not limited to the following:(a) federal Medicaid statutes and regulations; (b) state Medicaid statutes and rules; (c) federal and state statutes and rules governing transportation; (d) federal and state statutes regarding the privacy of health related data; and (e) Texas Administrative Code, Title 1, Part 15, Chapter 380 and Chapter 355, Subchapter J, Division 29, Rules §355.8561; and (f) Corrective Action Orders:

- Corrective action toll free numbers;
- Corrective action transportation program;
- Consent Decree *Frew v Janek; and*
- State Plan Amendment (SPA).

The MTO must expect that *Frew* requirements or statutory changes may occur during the term of the contract. Such changes could include, but not be limited to, changes in the law, the current *Frew* corrective action order(s) (CAO(s)), current corrective action plan(s) (CAP(s)), and/or the *Frew* consent decree (CD). The MTO will be bound by any changes in that amendment. The MTO must ensure that all policies and procedures adhere to all laws.

Additionally, in Attachment H (MTO Disclosures and HHSC Requirements), the MTO must ensure that it adheres to and follows all requirements as outlined.

2.17 Program Limitations

To assist the MTO in arranging appropriate transportation, program limitations that are not within the NEMT intent or scope can be found in the Texas Administrative Code (TAC), the State Plan Amendment (SPA), or 1915(b) Waiver.

2.18 MTO Service Manuals

2.18.1 Performing Provider NEMT Manual

The MTO must develop and maintain a Performing Provider NEMT manual and at a minimum require all policies and procedures for the MTO's Performing Providers. The MTO must develop a performance monitoring plan describing how it intends to monitor performance of all transportation services. The plan must be in compliance with all local, State and Federal laws, and regulations. The MTO must have written procedures in the plan for ensuring that an appropriate corrective action is taken when inappropriate or substandard services are provided or when services are out of compliance with federal or State laws or regulations. The MTO must report on the

monitoring activities as outlined in the reporting table. (See Attachment J, Contract Required Reports).

Additionally, the manual must describe the oversight procedure that will be in place to determine that all Performing Providers are legally licensed by the State of Texas to operate the vehicle to which they are assigned; be competent in their driving habits; be courteous, patient, and helpful to all passengers; and be neat and clean in appearance. The MTO must also describe how it will ensure that drivers provide services without additional charge to the client. The MTO may establish additional qualifications for drivers as needed.

The MTO must also describe in the manual their driver requirements including insurance, professionalism, compliance with applicable laws, passenger safety, and customer service.

The MTO must also describe driver records and related information that will be maintained in the files for demand response service Performing Providers.

Additionally, the MTO must describe how it will ensure the availability of a sufficient number of Performing Providers with a reliable fleet of vehicles, including Americans with Disabilities Act (ADA) compliant vehicles, available to meet the specified transportation timeliness and service requirements for all clients. The MTO must also develop, implement, and maintain an annual inspection process to verify that all vehicles used to provide demand response transportation services meet federal, state, and local ordinances. Moreover, the MTO must establish, maintain, and provide upon request documentation and records for each vehicle.

No later than forty-five (45) calendar days after the Contract is awarded, or upon a date approved by HHSC, the Performing Provider NEMT manual must be provided to HHSC, be available electronically through a link on the MTO's website and must be incorporated into all training programs for the MTO and Performing Provider staff.

2.18.2 Operating Procedures Manual

No later than forty-five (45) calendar days after the Contract is awarded, or upon a date approved by HHSC, the MTO must develop an operations procedures manual detailing all procedures to be used in the scheduling and delivery of services and adherence to the Limited English Proficiency requirement. The manual should also include a training plan that includes MTO and Performing Provider staff training requirements and how the MTO intends to satisfy these requirements.

2.18.3 Quality Assurance (QA) Plan

No later than forty-five (45) calendar days after the Contract is awarded, or upon a date approved by HHSC, the MTO must develop and maintain an ongoing Quality Assurance (QA) plan to support the provision of quality services. The QA plan must describe the range of controls designed to minimize program errors, corrective action resolution activities, or any business activity that may affect intended services described.

2.18.4 Business Continuity Plan

The MTO shall develop and submit a Business Continuity Plan as part of their response to the RFP that details how the MTO will be maintained in the future and that accounts for unexpected disruptions or unplanned events. The Business Continuity Plan must cover all aspects of daily operations and address various scenarios that could adversely impact daily operations.

2.18.5 Disaster Recovery Plan

The MTO shall develop and submit a Disaster Recovery Plan that details the processes it will follow to recover and protect its information technology business infrastructure in the event of a natural or man-made disaster.

2.18.6 Transition Plan

No later than forty-five (45) calendar days after the Contract is awarded, or upon a date approved by HHSC, the MTO must provide a Transition Plan to HHSC for approval. Thereafter, an updated Transition Plan will be due annually, if changed or updated, to coincide with the anniversary of delivery of the initial plan and as may be required by HHSC.

The Transition Plan must include the proposed approach to the transition; the tasks and subtasks, transition schedule, the operation resource requirements; any training to be provided; and procedures for the transfer of data, documentation, files, training materials, the operations procedures manual, brochures, pamphlets and all other written materials and records developed in support of MTP.

2.18.6.1 The Transition Plan must include:

2.18.6.1.1 Proposed approach to transition, in paragraph form, along with a work plan, including the tasks and time line schedule for the transition.

2.18.6.1.2 An estimate of the number of full-time equivalents (FTEs) and type personnel needed to operate all functions of the Transition Plan. The statement must be separated by service area and by type of activity of the personnel.

2.18.6.1.3 A statement of all facilities and resources currently required to operate the MTO's functions, including, but not limited to:

- data processing equipment;
- reservation/scheduling software;

- system and special software (data base and telecommunications);
- other equipment;
- office space;
- transport and service provider network; and
- a statement indicating that the MTO would have a license to utilize the MTO's software until the new MTO can become operational in that region.

2.18.6.1.4 The statement of resource requirements must be based on the MTOs experience, in the operation of the MTO functions; and must include actual vendor resources, devoted to the operation, of all tasks required by the contract.

2.18.6.1.5 The Transition Plan must be submitted to HHSC for acceptance and approval on the date set or within thirty (30) calendar days of a special HHSC request. After this date, the MTO must be assessed one percent (1%) of MTO's monthly payment until the Transition Plan is received and approved by HHSC.

2.18.6.1.6 In the event HHSC desires a transition of the duties and obligations of the MTO to HHSC or to a new MTO upon termination of the contract, HHSC must give written notification to the MTO of the need for transition at least 90 days prior to the termination date of the contract. The transition period shall begin on the date specified by HHSC in the notice and must continue until HHSC determines that all of the MTO's contract duties and obligations have been met, even if that date extends beyond the termination date of the contract. HHSC must provide written instructions in the notice regarding the packaging, documentation, data formats, delivery location, and delivery date of all records, data, and information HHSC determines are required to provide for an orderly transition.

2.19 Data Analysis

The MTO must analyze data collected from its phone system as required by HHSC and as necessary to perform quality assurance and quality improvement; fulfill the reporting and monitoring requirements; and ensure adequate staffing. Upon HHSC request, the MTO must document compliance in these areas.

2.20 Project Implementation Plan

The MTO shall develop and submit a comprehensive Project Implementation Plan as part of their response to the RFP that details all performance tasks, that outlines transition from the current service delivery model to the new transportation service

delivery model with full implementation being completed prior to August 1, 2014. The Project Implementation Plan must be sufficiently detailed to ensure that the work will be performed in a logical sequence, in a timely manner with the efficient use of resources. Each task identified in the plan should have an appropriate time frame for completion. Additionally, the respondent must include a narrative that provides an overview of the approach to successfully transition services. Contingency provisions must be explained to account for possible delays or unforeseen implementation challenges.

During the implementation phase, the MTO shall submit written weekly reports describing progress in attaining project activities.

2.21 Financial Management

2.21.1 Payment Administration

2.21.1.1 All payments made by the MTO to Performing Providers for goods and services rendered under the contract shall be in compliance with Title 10, Chapter 2251, Texas Government Code and 42 U.S.C. §1396a(a)(37)(A).

2.21.2 Validation Checks

The MTO must describe in their project work plan how it will validate that services paid under the Contract are properly authorized and rendered. The MTO must perform validation checks on at least five (5) percent of services rendered by its Performing Provider and/or Material Subcontractor no later than thirty (30) days following payment of service. HHSC, at its sole discretion, may require additional validation checks of services. Failure to achieve and report the required percentages in the format approved by HHSC may result in liquidated damages.

2.21.3 Reconciliation

HHSC reserves the right to have designated representatives conduct site visits, announced and unannounced to inspect records during normal business hours to monitor compliance in accordance with Contract requirements. The designated HHSC staff will conduct on-site reviews at the MTO's headquarters office to ensure that support documentation (i.e. driver logs, dispatch logs, trip manifests, authorizations containing client signatures), is available. Any claim that is found to be lacking in supporting documentation may be assessed liquidated damages.

2.21.4 Recoupment Process

HHSC will communicate with the MTO detailing the documentation that is required and needed supporting payment of identified subcontractor claims. The MTO will be responsible for the repayment of identified subcontractor claims. The MTO will be responsible for the repayment of overpayments to HHSC. Continued findings by HHSC designated monitoring staff in incorrect billing resulting in overpayments will be considered as a failure to meet the RFP requirements.

2.21.5 Claims Processing

The MTO must describe in their project work plan how it will develop and maintain a financial management system capable of processing billing electronically. HHSC must approve the financial management system during the Readiness Review period. The financial management system, at a minimum must:

- Include an electronic billing system that accurately compiles records and maintains billing data for client transportation services;
- Provide records that contain all pertinent documentation;
- Include accurate controls of verifiable documentation that HHSC prior approved delivered services; and
- Include accurate controls of verifiable documentation that services were in fact delivered.

2.22 Readiness Review

HHSC will require the MTO to execute a Project Implementation Plan described in Section 2.20 as finally approved by HHSC, with measurable milestones. Damages will be assessed for failure to successfully meet any proposed and agreed milestone(s). The MTO must complete a readiness review prior to the operational start date. The readiness review will be conducted in accordance with the milestones indicated in the project implementation plan. The requirements of the readiness review are described in this Section. Failure to successfully complete the operational review may be determined to be a material breach of contract. “Fully operational” means the MTO has been accepted and approved by HHSC to provide services in the awarded MTO service region.

2.22.1 Readiness Plan

2.22.1.1 The MTO shall submit an operational readiness plan which reflects the state's requirement of a fully operational program no later than August 1, 2014. At a minimum, the operational readiness plan shall address the following:

- Administrative office operations;
- Provider network within region;
- Staff training and knowledge of system and program requirements;
- Automation capacity, functionality, and interface with state systems;
- Verification of security and integrity of automated systems relevant to user access, protection of data and system availability (e.g. review of a recent SOC2 report or equivalent);
- Trip scheduling, authorization and client notification processes;
- Trip denial and appeals process;
- Processes to assure quality and appropriateness of transportation services;
- System readiness to submit encounter data;

- Written policies and procedures and business process flows that define program operations and protocols;
- Community resource identification and proposed utilization;
- Listing of local lodging/meal providers and establishment of agreements with these entities;
- Management of advanced funds distribution;
- Reporting procedures; and
- Business continuity plan

HHSC will coordinate a meeting with the selected MTOs within five (5) business days of execution of the contract to review contract requirements, specifically, report formats, project deliverables, finalize project implementation plan, review communications plan and discuss high risk areas or other challenges.

2.22.2 MTO Operational Readiness Review

2.22.2.1 Prior to the MTO becoming operational, the MTO must pass an HHSC operational readiness review process. Authorized HHSC representatives will visit the MTO facilities to confirm that all systems are operational and ready for full-time service. The MTO must receive written HHSC approval of all submission and demonstration requirements.

2.22.2.2 The MTO will have an opportunity to make adequate corrections, within an HHSC provided timeframe. The MTO will have an opportunity to make corrections and submit proof that corrections were completed and successfully implemented, prior to becoming operational.

2.22.2.3 If HHSC, at its sole discretion, determines the MTO is not ready to become fully operational, the MTO will be assessed a liquidated damage. Payment will also be withheld until the MTO passes the operational readiness acceptance and approval. Once operational readiness review is completed and approved by HHSC, the MTO will be allowed to view service requests to prepare for providing services on operational start date.

2.22.2.4 Drafts of the following must be included with the proposal response described in 3.17.1.3 (Project Work Plan):

- Project Implementation Plan;
- Information systems and reporting capabilities;
- Training Manual;
- Insurance Certifications as applicable; and
- Sample of Performing Provider Agreements.

2.22.2.5 Business Continuity and Disaster Recovery plans;

2.22.2.6 All other documentation, plans and manuals required in the RFP must have HHSC approval prior to the Readiness Review.

Documentation of HHSC approval must be available on site during readiness testing:

2.22.2.7 The Readiness Review will require the MTO to demonstrate readiness of personnel and fully operational systems. This will include but is not limited to the following:

- Telephone systems;
- Automation systems;
- Communications systems;
- Sufficient MTO and Performing provider staffing;
- Complaint system procedures;
- After-hours coverage arrangements;
- Performing Provider NEMT Manual;
- MTO Vehicle inspection report forms;
- Verification of State Vehicle Inspection;
- Roster of MTO key personnel and staffing;
- HIPAA Training completion;
- Performing provider files;
- Driver files;
- Roster of Performing Providers;
- Roster of drivers;
- Customer satisfaction survey; and
- Verification of meetings conducted within the MTO service region, for medical providers, to assist with understanding the program.

2.22.3 Financial Readiness Review

To complete a financial review, the MTO must submit a Financial Update Report to HHSC no later than sixty (60) days prior to the Operational Start Date. At a minimum, the report must include the following:

2.22.3.1 Material Change in Financial Condition

For both the MTO and its ultimate parent, the report must identify whether either entity has experienced any material financial deterioration following proposal submission. The report must identify and briefly describe any changes to the financial statements, including changes to net worth; cash flow; loss of contracts; credit, audit, regulatory, and/or legal issues; major contingencies, etc. The report must also describe any known potential issues, and any issues with respect to change of ownership or control.

2.22.3.2 Updated Financial Statements

The report must include the most recently updated financial statements, which should be more current than those provided in the proposal. The updated financial statements should include the most recent quarterly (or monthly) internal financial statements, the most-recently completed annual statements, and the most-recent audited statements. The statements should generally include the notes, management discussion, and where

appropriate, the audit letter. Internal most-recent-month statements are not expected to include these items.

The report must include any of the following new or updated reports that have become available since proposal submission: TDI financial examination report (or similar report from another state); Form B Registration statement filing; Internal Revenue Service (IRS) Form 990; and bond or debt rating analysis. It is not necessary to submit updated U.S. Securities and Exchange Commission (SEC) 10-K or 10-Q filings with the report.

In addition to the Financial Update Report, the MTO must submit documentation demonstrating it has secured all required bonds in accordance with TDI requirements. Such documentation is due no later than ten (10) business days after the Contract Effective Date.

2.22.3.3 Employee Bonus and/or Incentive Payment Plan

If the MTO intends to include Employee Bonus or Incentive Payments as allowable administrative expenses, the MTO must furnish a written Employee Bonus and/or Incentive Payments Plan to HHSC. The written plan must include a description of the MTO's criteria for establishing bonus and/or incentive payments, the methodology to calculate bonus and/or incentive payments, and the timing of bonus and/or incentive payments. The Bonus and/or Incentive Payment Plan and description must be submitted during the Transition Phase, no later than thirty (30) days after the Effective Date of the Contract. If the MTO substantively revises the Employee Bonus and/or Incentive Payment Plan during the Operations Phase, the MTO must submit the revised plan to HHSC at least thirty (30) days in advance of its effective date.

HHSC reserves the right to disallow all or part of a plan that it deems inappropriate. Any such payments are subject to audit, and must conform to Cost Principles for Expenses, see Attachment K.

2.23 Recordkeeping and Record Retention

In the project work plan, the MTO must describe policies and procedures for records retention, archival, and retrieval functionality of data that comply with the state record retention requirements in their response. This must include a description of the format of archived data and the appearance and methods of use for archived data once it is restored.

The MTO must at a minimum keep records related to:

- Eligibility documentation;
- Travel services:
  - Trip approvals, no shows, cancellations and reschedules
  - Provider assignments
  - Appropriate mode of transportation
  - Mass transit
  - Demand response services
  - Airline services

    - Advanced funds
    - Lodging
    - Meals
- Clients, claims, financial supporting documentation for monitoring, or audit. Claims and financial documents for transportation services must be kept separate from other funding sources;
- Employee training;
- Performing Provider agreements;
- Business Associate Agreements (see Attachment T) for Performing Providers listed on the MTO's approved Performing Provider roster;
- Performing Provider vehicles;
- Performing Provider drivers;
- Complaints; and
- Telecommunication metrics.

2.24 Reporting

The MTO must describe in the project work plan policies and procedures to coincide with the requirements specified in the reporting table (See Attachment J. Contract Required Reports). The MTO may include unique or innovative features and advantages/benefits to HHSC. Additionally, the MTO is required to report service data to HHSC or the designated vendor. The MTO is also responsible for ensuring that all reporting requirements relating to data or reports is made available to HHSC as requested.

The MTO must advise HHSC when an error is identified within the time frame specified by HHSC. Additionally, the MTO must provide ad hoc or special reports at the request of HHSC and respond within two (2)business days, including reporting specifications, report development, cost, and the expected delivery date of information.

2.25 Annual Fiscal Audit Report

The MTO must provide for an independent professional external audit of its financial records for each MTO fiscal year that is included, or partially included, in the duration of the contract term as prescribed under Sections 6.2.1.1 and 6.17.1.

2.26 Information Technology (IT Specifications)

This section describes the requirements that MTO must fulfill with regards to the computer systems and automated processes to support the operational and reporting functions. It does not mandate what specific software or technologies to use, but requires that systems and processes be automated and that these systems meet the requirements described in this section.

The MTO and all subcontractors, vendors, agents, and service providers of or for the MTO must not allow any Confidential Information the MTO receives from or on behalf of HHSC to leave the United States at any time, for any period of time, for any reason.

The MTO and all subcontractors, vendors, agents, and service providers of or for the MTO must perform all services under the Agreement, including all tasks, functions, and

responsibilities assigned and delegated to the MTO under this Agreement, within the United States. This includes, but is not limited to, all IT Services (including but not limited to processing, transmission, storage, archiving, data center services, disaster recovery sites and services, customer support), and call center technical support services.

2.26.1 Management Information System Requirements

2.26.1.1 The MTO must maintain an Information Technology System (ITS) that supports all functions of the MTO's processes and procedures for the flow and use of MTO data. The MTO must have hardware, software, and a network and communications system with the capability and capacity to handle and operate all IT subsystems for the following operational and administrative areas:

- Eligibility Subsystem;
- Authorization Subsystem;
- Provider Subsystem;
- Encounter/Claims Processing Subsystem;
- Financial Subsystem;
- Utilization/Quality Improvement Subsystem;
- Reporting Subsystem; and
- Interface Subsystem as applicable to each MTO.

2.26.1.2 The ITS must enable the MTO to meet the contract requirements, including all applicable state and federal laws, rules, and regulations and must have the capacity and capability to capture and utilize various data elements required for MTO administration.

2.26.1.3 The MTO must have a system that can be adapted to changes in Business Practices/Policies within the timeframes negotiated by the Parties. The MTO is expected to cover the cost of such systems modifications over the life of the Contract.

2.26.1.4 The MTO must provide HHSC written notice of major systems changes and implementations no later than 180 days prior to the planned change or implementation, including any changes relating to Material Performing Providers, in accordance with the requirements of the contract and the "Uniform Contract Terms and Conditions." HHSC retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MTO.

2.26.1.5 The MTO must provide HHSC any updates to the MTO's organizational chart relating to ITS and the description of ITS responsibilities at least thirty (30) days prior to the effective date

of the change. The MTO must provide HHSC official points of contact for ITS issues on an ongoing basis.

2.26.2 IT Systems Readiness Review

2.26.2.1 HHSC, or its agent, may conduct a Systems Readiness Review to validate the MTO's ability to meet the MIS requirements. The System Readiness Review may include a desk review and/or an onsite review.

2.26.2.2 If for any reason a MTO does not fully meet the IT requirements including security, then the MTO must, upon request by HHSC, either correct such deficiency or submit to HHSC a Corrective Action Plan and Risk Mitigation Plan to address such deficiency. Immediately upon identifying a deficiency, HHSC may impose contractual remedies according to the severity of the deficiency.

2.26.2.3 The MTO must submit descriptions of interface and data and process flow for each key business processes described in Section 2.29, IT System-Wide Functions.

2.26.2.4 The MTO must assure that systems services are not disrupted or interrupted during the operations phase of the contract. The MTO must coordinate with HHSC and other contractors to ensure the business and systems continuity for the processing of all transportation services authorizations and data as required under the contract.

2.26.2.5 The MTO must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities. No later than ninety (90) days prior to the operational start date, MTOs must develop the following plans:

- Disaster Recovery Plan*;
- Business Continuity Plan*;
- Security Plan;
- Joint Interface Plan (also known as Interface Management Plan)**; and
- Risk Management Plan.

*The Business Continuity Plan and the Disaster Recovery Plan may be combined into one document. The MTO must review these plans with HHSC and update and finalize these plans based on input provided by HHSC prior to the operations start date.

**For an example of a Joint Interface Plan see Attachment U.

During this Readiness Review task, the MTO will accept into its system any and all necessary data files and information available from HHSC or its contractors. The MTO will install and test all hardware, software, and telecommunications required to support the Contract. The MTO will define and test modifications to the MTO's systems required

to support the business functions of the Contract.

2.26.3 MTO Deliverables Related to IT Requirements

At the beginning of each State Fiscal Year, the MTO must submit the following documents and corresponding checklists for HHSC's review and approval.

2.26.3.1 Deliverables

2.26.3.1.1 Disaster Recovery Plan;[2]
2.26.3.1.2 Business Continuity Plan;[3]
2.26.3.1.3 Security Plan;
2.26.3.1.4 Joint Interface Plan; and
2.26.3.1.5 Risk Management Plan.

The MTO must follow all applicable Joint Interface Plans (JIPs) and all required file submissions for the Claims Administrator.

2.26.4 IT Security

Automated systems and procedures related to MTP operations must meet all Federal and State privacy and security requirements in addition to specifications detailed in this RFP. Specific security requirements are documented below:

The following resource links should be used when developing plans that assess security risk for this directive, as summarized below:

- Texas Administrative Code, Title 1, Part 10, Chapter 202
- FIPS Publication 200
- NIST Special Publication 800-53

A security plan template can be found in the procurement library.

2.26.5 Logical Security of Information Systems

The MTO is responsible for developing plans that assess security risks associated with the servers, workstations, applications, and websites that access or maintain HHS confidential information. The plans must include appropriate actions to mitigate any identified risks to address vulnerabilities.

2.26.6 Servers and Workstations

The MTO must have well documented processes to protect the automated systems and information resources against accidental or unauthorized access, disclosure, damage

[2] The Business Continuity Plan and the Disaster Recovery Plan may be combined into one document.
[3] The Business Continuity Plan and the Disaster Recovery Plan may be combined into one document.

and loss.

- Security patches and other software updates – HHS Enterprise Information Security Standards and Guidelines require that all operating system software have appropriate patches, and that security-related operating system or software application patches be reviewed and installed in a timely manner, consistent with the criticality and vulnerability of the resource.

- Administrator accounts –Each user of information resources shall be assigned a unique identifier except for situations where risk analysis demonstrates no need for individual accountability of users. User identification shall be authenticated before the information resources system may grant that user access. The MTO will ensure a user's access authorization is modified or removed when the user's employment or job responsibilities change.

Passwords –minimum password length, complexity, password expiration intervals, and lockout settings for failed login attempts must be enforced.

- The MTO must demonstrate adequate and separate functions for tasks susceptible to fraud or other unauthorized activity.
- The MTO must demonstrate that the systems have an authentication mechanism that is secure and limits access to the information based on user functions.
- The MTO must demonstrate and ensure that data related to MTP operations and clients is protected.

2.26.7 Security of Back-up Media that Store Confidential Information

The MTO must develop plans that assess security risks associated with controls for their back-up media that store confidential information. Additionally, the MTO must demonstrate that confidential information will not be stored on non-agency owned or removable media that are not encrypted.

- The MTO must demonstrate and ensure that data related to MTP operations is backed up, encrypted appropriately, and must submit a backup and recovery plan.
- The MTO must provide a 24/7 system maintenance and support service for system failures that would prevent a client from receiving services.
- The MTO must not share or disclose information to any resources other than HHSC unless mandated by law without prior consent from HHSC.
- The MTO must report to HHSC IT any breach of security or un-authorized access within six (6) hours.
- The MTO must ensure that all confidential information is disposed in a safe and secure manner.
- The MTO must provide user access through role-based security. The application must provide tests for authentication (login process) and role based security, authorization (determines whether a user has the required role to access a resource.
- The MTO must ensure unauthorized users do not gain access to records.
- The MTO must create, protect and retain IT system audit records to enable the

monitoring, analysis, investigation and reporting of unlawful, unauthorized, or inappropriate IT system activity; and ensure that the actions of individual IT systems users can be uniquely traced to those users so they can be held accountable for their actions.

2.26.8 Software Requirements

This RFP does not mandate what specific software or technologies to use, but requires that systems and processes be automated and that these systems meet the requirements described in this section.

2.26.9 Use of Confidential Information in Non-Production (Test) Environments

The MTO must develop plans that assess security risks associated with their use of confidential information that is not declassified in non-production (test) environments and take appropriate actions to mitigate any identified risks to address vulnerabilities. Where business need and acceptance of risk justifies the use of confidential information in non-production environments, all employees with access to the confidential information must be authorized and approved by the business owner. Access control requirements and all system security measures required to assure that confidential information is not accessible to unauthorized personnel must be in place. If security measures are not capable of preventing unauthorized access, confidential information must be de-identified (removal of client SSI, PHI, names, addresses etc.) and protected in compliance with the Data Use and Business Associate Agreement or an exception to HHS Enterprise policy must be documented, approved by HHSC and processes must be implemented to ensure that confidential data resides in the non-production environment for the minimum length of time required for development and testing purposes.

2.26.10 System Testing and Transfer of Data

2.26.10.1 The MTOs must perform system readiness testing at their cost prior to go-live of the contract.

2.26.10.2 The MTOs must demonstrate readiness for operations by installing and testing all hardware, software, and telecommunication equipment required to support the contract.

2.26.10.3 The MTOs must test and verify secure file exchanges required for operational readiness.

2.26.10.4 The MTOs testing must include ability to handle data large volumes of data commensurate to the population of clients served.

2.26.10.5 The MTOs agree to report and perform readiness testing of any new systems or software changes that is implemented during the term of the contract.

2.26.10.6 The MTO must have hardware, software, network and communications systems with the capability and capacity to handle and operate all IT systems and subsystems identified in Section 2.26.1, (Management System Requirements). For example, the MTO's IT system must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as indicated in Section 2.30.

2.26.10.7 The MTO will produce data extracts and receive all electronic data transfers and transmissions.

2.26.10.8 If any errors or deficiencies are evident, the MTO will develop resolution procedures to address problems identified. The MTO will provide HHSC, or a designated vendor, with test data files for systems and interface testing for all external interfaces. This includes testing of the required telephone lines for MTOs and any necessary connections to the HHSC Systems. The MTO will demonstrate its system capabilities and adherence to Contract specifications during Readiness Review.

2.26.11 Telecommunications Platform

The selected respondent shall utilize a cloud based telephony infrastructure provided by HHSC for transportation service requests. This infrastructure will be hosted and maintained by an HHSC selected vendor (cloud vendor). HHSC will provide a secure network to connect to the hosted telephony solution. Cloud systems provided by HHSC are voice infrastructure only.

2.26.11.1 Key Features Provided by HHSC's Cloud Vendor

- To route callers to the correct vendor and Automatic Call Distribution (ACD) queues, a cloud-based Interactive Voice Response (IVR) system will prompt callers for Dual tone Multi-Frequency (DTMF) entry of:
  - Language;
  - ZIP code; and
  - Medicaid Number.

- Cloud IVR will provide all call routing and queue prompts, courtesy hold messages, disaster routing and emergency closure notices. Vendor will not need to provide an IVR or auto-attendant for transportation services calls.

- An automatic call distribution system (ACD) that will provide separate queues:
  - Based on language selection;
  - ZIP code;
  - Based on Medicaid number provided in IVR, for designation of
    - Children on Medicaid, birth through age 20; and

- All other clients.
  - Provide routing to additional queues, a necessary; and
  - Generate real time and historical reports.

- Voicemail for agent phones.

- Call monitoring and evaluation system that includes:
  - Audio recording of all calls
  - Agent evaluation tools.

In addition, HHSC will provide the following:

- Installation of telephony platform,
- Cabling from the Main Distribution Frame (MDF) to the agent desktop,
- Remote and onsite maintenance of HHSC provided telephony equipment and cabling,
- Initial training to vendor on ACD reports, audio recording and call monitoring systems.

High Level Call Flow

- Caller dials single toll-free number for transportation services (1-877-633-8747).
- Cloud answers
- Cloud IVR prompts for language, ZIP code, Medicaid number
  - Call routed to appropriate vendor queues (that reside in the cloud)
    - Children on Medicaid, birth through age twenty (20), English
    - Children on Medicaid, birth through age twenty (20), Spanish
    - All other callers, English
    - All other callers, Spanish
  - Cloud IVR provides music and hold messages
  - Cloud ACD provides priority handling for Children on Medicaid, birth through age 20 queues
  - Vendor agent (who is logged in) receives call.

2.26.11.2 The selected respondent shall be responsible for:

- Providing appropriate electrical power and environment suitable for telecommunications equipment,
- Providing secure space for HHSC provided equipment, including switch(es) and gateway,
- Providing necessary access for cabling, installation and maintenance,
- Providing access for HHSC or cloud vendor to conduct site surveys, testing, maintenance and repair of equipment,
- Local data network,

- Agent computers,
- Headsets compatible with provided telephones,
- Providing local telephone service to voice gateway,
- All telephony services for outbound calls,
- All fax telephony services and / or solutions,
- Internet connection for accessing cloud reporting, and
- Initiating requests through the HHSC IT Customer Service Help Desk, as required, for incidents and change requests.

2.27 Demonstration of Assessment of System Readiness

2.27.1 Physical Security of Data Centers, Server Locations, and Back-up Sites

Unauthorized disclosures of confidential data could compromise the privacy of HHS clients. The MTO must develop plans that assess weaknesses in physical security that can result in unauthorized access to facilities hosting, processing, transmitting, or storing their confidential data or systems, and take appropriate actions to mitigate any identified risks. Assessments should consider areas where IT resources are located in areas that are publicly accessible, restricted area entry and exit points secured to assure appropriate access, as well as server rooms to ensure construction and entry are adequate to protect systems contained within.

The MTO must provide documentation on systems and facility security and provide evidence or demonstrate that it is compliant with HIPAA. The MTO must also provide HHSC with a summary of all recent external audit reports, including findings and corrective actions, relating to the MTO's proposed systems, including any SAS70 audits that have been conducted in the past three (3) years. The MTO must promptly make additional information on the detail of such system audits available to HHSC upon request.

In addition, HHSC will provide to the MTO a test plan that will outline the activities that need to be performed by the MTO prior to the Operational Start Date(s). The MTO must be prepared to assure and demonstrate system readiness. The MTO must execute system readiness test cycles to include all external data interfaces, including those with Material Performing Providers.

HHSC, or its agents, may independently test whether the MTO's IT System has the capacity to administer the transportation services business. This Readiness Review may include a desk review and/or an onsite review. HHSC may request additional documentation to support the provision of MTO Services. Based in part on the MTO's assurances of systems readiness, information contained in the Proposal, additional documentation submitted by the MTO, and any review conducted by HHSC or its agents, HHSC will assess the MTO's understanding of its responsibilities and the MTO's capability to assume the MIS functions required under the Contract.

2.27.2 IT Operations Readiness

The MTO must clearly define and document the policies and procedures that will be

followed to support day-to-day business activities related to the provision of Services under the contract, including coordination with Performing Providers and HHSC's contractors. The MTO will be responsible for developing and documenting its approach to quality assurance.

2.27.3 IT Assurance of System and Operational Readiness

In addition to successfully providing the deliverables described in the preceding sections, the MTO must assure HHSC that all processes, IT systems, and staffed functions are ready and able to successfully assume responsibilities for operations prior to the Operational Start Date. In particular, the MTO must assure that IT systems and interfaces are in place and functioning properly.

2.28 Encounter Data

The MTO must provide complete Encounter Data for all transportation services including meals, lodging, and advanced funds, offered to clients. Encounter Data must follow the format and data elements as described in the HIPAA-compliant 837P Companion Guides and Encounter Submission Guidelines or comparable format as determined by HHSC. HHSC will specify the method of transmission and the submission schedule. The MTO must submit Encounter Data transmissions at least monthly, and include all Encounter Data and Encounter Data adjustments processed by the MTO. Encounter Data quality validation must incorporate assessment standards developed jointly by the MTO and HHSC. The MTO must submit complete and accurate Encounter Data not later than the 30th calendar day after the last day of the month in which the claim was adjudicated. The MTO must make original records available for inspection by HHSC for validation purposes. Encounter Data that does not meet quality standards must be corrected and returned within a time period specified by HHSC.

For reporting claims processed by the MTO and submitted on the prescribed Encounter 837P format or comparable format as determined by HHSC, the MTO must use the procedure codes, diagnosis codes, provider identifiers, and other codes as directed by HHSC. Any exceptions will be considered on a code-by-code basis after HHSC receives written notice from the MTO.

2.28.1 Encounter Data Submission Requirements

MTO will be required to submit accurate and complete Encounter Data for all Covered Services. The Encounter Data must follow the format, rules**,** and data elements required by HHSC and described in the current HIPAA-compliant 837P Professional Companion Guide and TMHP Encounter Submission Guidelines or a comparable format as determined by HHSC. The final guidelines will be added to the procurement library.

HHSC may periodically change or update the format and content requirements for encounter data submission and MTO must make any system or process change necessary to comply with HHSC requirements.

2.28.1.1 Encounter Data should be a comprehensive and accurate depiction of the processed claim content from the MTO/FRB Claim system. It is expected that MTO claims processing for

both paper and electronic systems will comply with the requirements of the 837 Professional transaction or a comparable format. Claims processed by the MTO and submitted on an 837P transaction or comparable format must contain all HHSC prescribed data elements including but not limited to HIPAA-compliant procedure codes, diagnosis codes, and provider identifiers.

2.28.1.2 MTO must submit complete and accurate Encounter Data at least monthly, but not later than the 30th calendar day after the last day of the month in which each claim was adjudicated. The MTO must make original records available for inspection by HHSC for validation purposes. Encounter Data that does not comply with business edit or HIPAA transaction requirements will be rejected or identified as requiring additional action. MTO must maintain a process to monitor the status of submitted Encounter Data and correct and resubmit any applicable Encounter Data within a time period specified by HHSC.

2.28.1.3 At a minimum, the file must include the following data elements:

- MTO Plan Code (issued by HHSC)
- Client Details
  - Subscriber's Patient Control Number (PCN)
  - Subscriber Last Name
  - Subscriber Middle Name
  - Subscriber First Name
  - Subscriber DOB
  - Subscriber Address
  - City
  - State
  - ZIP
- Funding Program (Medicaid, CSHCN, TICP)
- Healthcare Provider
- Provider NPI
- Provider Tax ID
- Provider SSN
- Provider TPI plus suffix (01, 02, etc.)
- Provider Name
- Address
- City
- State
- Zip
- Provider Phone
- Provider Specialty
- Appointment Details
  - Appointment Date From (healthcare appt.)
  - Appointment Date To (healthcare appt.)
- Type of Service:

        - Demand Response
        - Mass Transit Tickets
        - Individual Transportation Participant
        - Meals
        - Lodging
        - Advanced Funds
        - Out-of-State Travel
        - Airline
        - Nonemergency Ambulance Transport
    - From Date of Service (travel date)
    - To Date of Service (travel date)
    - Origination Address
        - Address
        - City
        - State
        - ZIP
    - Destination Address
        - Address
        - City
        - State
        - ZIP
    - Special Needs
    - Trip Details
        - One-Way Trips
        - Meals Units
        - Lodging Units
        - Number of Miles
        - Number of Attendant(s)
    - Claim Details
        - Authorization Number
        - Procedure Code
        - Paying ICN
        - Cost of Service (Total Payer /MTO Paid Amount)
        - Claim Adjustment Group Code
        - Claim Adjustment Reason Code
        - Claim Adjustment Amount
        - Trip Verification On File Indicator
    - Billing Provider (Transportation Provider)
        - Provider NPI
        - Provider Tax ID or SSN
        - Provider API
        - Provider Name
    - Performing Provider (Actual Driver)
        - Driver License Number

2.29 IT System-Wide Functions

The MTO's IT system must include key business processing functions and/or features, which must apply across all subsystems as follows:

- Process electronic data transmission to add, delete or modify membership records with accurate begin and end dates.

- Track transportation services received by clients through the system, and accurately and fully maintain those transportation services as HIPAA-compliant Encounter transactions.

- Transmit or transfer Encounter Data transactions through a secure file transfer in the format specified in Section 2.29.1 to the contractor designated by HHSC to receive the Encounter Data.

- Maintain a history of changes and adjustments and audit trails for current and retroactive data.

- Maintain procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure.

- Employ industry standard medical billing taxonomies (procedure codes, diagnosis codes, NDC codes) to describe services delivered and Encounter transactions produced.

- Pay financial transactions to Performing Providers in compliance with federal and state laws, rules and regulations.

- Relate and extract data elements to produce report formats required by HHSC.

- Ensure that written process and procedures manuals document and describe all manual and automated system procedures and processes for IT.

2.30 Health Insurance Portability and Accountability Act (HIPAA) Compliance

The MTO's MIS system must comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, P.L. 104-191 (August 21, 1996), as amended or modified.

The MTO must provide its Members with a privacy notice as required by HIPAA. The MTO must provide HHSC with a copy of its privacy notice during Readiness Review and any changes to the notice prior to distribution.

2.31 Communication Equipment

In the project work plan submitted with its proposal, the MTO must detail the communication equipment including computers, telephone, fax, etc. that will be used to fulfill the requirements of the RFP, including how communication among clients,

Performing Providers, and the MTO will be managed to ensure that there are no delays in services or in emergency relief and how the system will be available 24 hours a day, 7 days a week. Additionally the MTO must describe how it will notify HHSC when any communication system is not functioning and how it will be resolved.

2.32 Specific Closeout Requirements

The MTO must complete all duties required in the RFP with regard to requests for services for dates of services up to and including 11:59 p.m., Central time and Mountain time on the termination date of the contract. These duties include but are not limited to:

- Scheduling, authorization and provision of transportation services;
- Successful submission to HHSC of all client information;
- Generation and submission of all required notices to providers and clients;
- Transfer of all data and files to HHSC
- Submission and correction as necessary of all reports required; and
- Successful transition to new MTO

2.33 Key Performance Requirements and Associated Remedies

HHSC will monitor the performance of the contract issued under this RFP. All services and deliverables under the contract shall be provided at an acceptable quality level and in a manner consistent with acceptable industry standard, custom, and practice. HHSC will regularly monitor the MTO's activities to ensure the MTO's performance.

The Key Performance Requirements (KPRs) will be used to gauge the MTO's commitment to successful performance and its confidence in its ability to perform. However, all areas of responsibility and all requirements in the Contract will be subject to performance evaluation by HHSC. Any and all remedies applied and either actual or liquidated damages assessed, as determined by HHSC.

HHSC will include standard remedies in the contract resulting from the RFP. Article 11 of the UTC 1.4.1 as may be modified, provides Tailored Remedies, including administrative remedies in the form of Liquidated Damages. Attachment S, MTO Key Performance Requirements identifies key performance measures and associated liquidated damages relating to this RFP.

Examples of tailored remedies include:

- Assessment of a proportional share of any federal disallowances and sanction/penalties imposed on the state and resulting from the MTO's performance or non-performance under the contract.

- Actual and consequential damages.

- Additional or ad hoc reporting by the MTO, at no cost to HHSC, to address performance issues.

- Accelerated monitoring of the awarded MTO's performance by HHSC or its designee, including access to the awarded MTO's facilities, records, data, information systems and personnel.

- Withholding or set-off of payment to the awarded MTO.

- Assessment of liquidated damages in accordance with State law.

- Equitable remedies as provided by State law.

The liquidated damages indicated in Attachment S of this RFP will be used to assign financial responsibility if the vendor fails to achieve the required key performance standards.

- The vendor must report all instances of non-performance to HHSC as soon as non-performance issue is detected in writing and via e-mail (including text message, pager, and any other relevant form of communication as determined by HHSC) within 24 hours of the incident.

- Liquidated damages will start to accumulate immediately upon the MTO's deficiency.

- If a performance deficiency is corrected during the "cure period" associated with that particular performance measure and liquidated damages, HHSC, at its sole discretion may waive the assessment.

- If a deficiency is not corrected during the specified "cure period," then all liquidated damages from the start of the deficiency, including the "cure period," may be assessed.

- Liquidated damages stop accumulating upon written acceptance, and approval of the vendor's corrective action.

- Except as noted otherwise, Calendar day versus business day rules apply.

2.34 *Frew* Consent Decree and Corrective Action Order Requirements

A contract awarded through this procurement will require the MTO to meet obligations contained within the 1996 *Frew* Consent Decree and 2007 Corrective Action Order: Toll Free Numbers. The MTO must incorporate these obligations into its proposal. Please note that throughout these sections the acronym "EPSDT" (Early and Periodic Screening, Diagnostic & Treatment) is used and it relates to Medicaid services for clients birth through age 20. In Texas, EPSDT is also known as Texas Health Steps (THSteps).

Portions of the February 1996 *Frew* Consent Decree (CD) and 2007 Corrective Action Order (CAO) are set out below. Some provisions are set out word for word, and others are only partially quoted, summarized, or paraphrased. The proposal must address how the MTO will meet the obligations of the CD and CAO, and meet HHSC's requirements as described throughout this RFP. Requests for further

clarification may be submitted as Vendor Questions to be discussed at the Vendor Conference.

In its proposal, the MTO must describe how it will provide the services listed above and describe the process by which it will allocate these services among clients (i.e., how the MTO will determine under what circumstances air, train, bus, demand-response, and other forms of transportation will be provided) in conjunction with Sections 2.3 of this RFP.

The Proposal must include how the MTO will manage the provision of hotel and meal services in conjunction with Sections 2.3.4 of this RFP. The MTO is strongly encouraged to consider HHSC's current reimbursement rate for meals, which is $25/day per person for meals for adults or children.

The MTO must describe how it will respond to and process urgent requests for transportation. This description must include how the MTO will balance (1) a client's need for transportation; (2) the TAC's requirement to manage transportation requests (Texas Administrative Code, Title I, Part 15, Chapter 380, Subchapter B, Rule §380.205 [1-3]) and; (3) the MTO's own business interests. The MTO must also describe how it will train transportation staff to respond to and process urgent requests for transportation.

CD 232. " …Beginning September 1, 1995, the rate will be the same as the reimbursement rate for state employees (currently 28 cents/mile). The Medicaid reimbursement rate will change whenever the state employee reimbursement rate changes in the future."

The MTO must acknowledge that it will monitor the going rate of reimbursement for state employees, and will provide clients a mileage reimbursement rate at no less than the going rate for state employees.

Currently, HHSC sets the reimbursement rate consistent with the Texas Administrative Code (TAC) Rule §355.8561.

Additionally, the current state mileage reimbursement rate may be found at:
https://fmx.cpa.state.tx.us/fm/travel/milerate/index.php

The proposal must describe how the MTO will manage the processing of claims and ensure prompt payment to drivers as part of its response to this RFP. The MTO must reimburse drivers within thirty (30) days of submission of a request for reimbursement; however, HHSC will favorably evaluate a proposal that assures more prompt and timely payment.

The MTO must include the process it will use to determine the distance it will transport a client. This description must include how the MTO will balance (1) a client's desire to establish and/or maintain a relationship with a provider in a certain area; (2) the TAC's requirement to provide reasonable transportation (Texas Administrative Code, Title I, Part 15, Chapter 380, Subchapter A, Rule §380.101 [35]) and; (3) the MTO's own business interests.

2.34.1 HHSC Reports, Studies and Assessments related to *Frew*

HHSC will have certain obligations regarding required reports, studies, and/or assessments of the Medical Transportation Program. The MTO must (1) explain its commitment to cooperate with HHSC in assessment activities of the MTO's program, as carried out by an independent, external evaluator, as required by the Consent Decree. The MTO must demonstrate an understanding of the vital role such cooperation will play in HHSC's compliance with the obligations contained in the *Frew* Orders and (2) propose how they will cooperate with HHSC in this regard. The MTO must (3) demonstrate that they agree to cooperate with the study of the following areas of the program, which may include, but not be limited to:

- Unmet need for transportation assistance;
- Client and provider satisfaction with the Medical Transportation Program;
- Reasons for client and provider dissatisfaction with the Medical Transportation Program;
- Whether transportation times are reasonable; and
- Whether clients missed or did not schedule EPSDT services because of transportation problems, including those attributable to Medical Transportation Program deficiencies.

The proposal must (1) describe the MTO's quality assurance and performance improvement processes that will ensure continuous improvement during the term of the contract and (2) agree that if program studies conducted by HHSC, or an independent vendor reveal deficiencies, the MTO will develop a plan to address the deficiency.

2.34.2 *Frew* Consent Decree and CAO: Toll Free Number Requirements: Call Center

The MTO must meet specific call center performance metrics, for calls to the Client Toll-Free Line for transportation services from a caller requesting transportation services for a person with Medicaid from birth through age 20. HHSC has provided these court ordered standards, and the proposal must describe how the MTO will implement these standards, including steps the MTO will take to ensure standards are met and all remedial actions that will be taken, if any standard is in jeopardy.

2.34.3 *Frew* Consent Decree Requirements, ¶247 - Well Trained

Toll-free numbers for EPSDT clients will be staffed sufficiently by well trained personnel. Each client will receive prompt service by a person who is knowledgeable.

All MTO staff answering calls to the Client Toll-Free Line for transportation services from a caller requesting transportation services for a person with Medicaid from birth through age 20 will receive thorough training. Initial training will be shared with HHSC prior to implementation; all subsequent changes will be shared with HHSC within five days of implementation. All staff will be tested on the content of the trainings (initial trainings, plus all subsequent coaching, counseling re-training on both previously trained topics and new topics). The MTO will design these tests to challenge staff understanding and comprehension of MTO training materials.

In addition to training on scheduling services for a caller requesting transportation services for a person with Medicaid from birth through age 20, training must include use of the call center equipment. Training must also cover all aspects of staff behavior that could impact a caller requesting transportation services for a person with Medicaid from birth through age 20 (e.g., relevant HIPAA training, phone etiquette, etc.).

While these training documents and tests do not need to be submitted with the RFP response, training materials and all tests need to be submitted, post-award, eight weeks prior to any training of MTO staff or contractors, to allow HHSC adequate time for review and approval. Additionally, the proposal must include a Training Plan that describes the MTO's proposed training methods, resources the MTO will employ to develop and implement the training, and a proposed development and implementation schedule. The MTO's implementation of the Training Plan will be included in the Readiness Review.

2.34.4 *Frew* Consent Decree Requirements, ¶247 Helpful and Polite

Each client will receive prompt service by a person who is helpful and polite.

The MTO must record all answered calls to the Client Toll-Free Line for transportation services from a caller requesting transportation services for a person with Medicaid from birth through age 20 in their entirety. In addition to call monitoring all MTO staff answering calls to the Client Toll-Free Line for transportation services from a caller requesting transportation services for a person with Medicaid from birth through age 20 must be monitored and scored for an additional 2% (for a total of 4%). The MTO must include a draft evaluation form for calls to the Client Toll-Free Line for transportation services from a caller requesting transportation services for a person from birth through age 20. Further, the MTO must ensure that monitoring evaluation forms, scoring and monthly quality activity reports fully address all *Frew* components in this section.

MTO must describe the procedures, controls, and standards of conduct it will require of staff answering calls, including how it will measure and ensure that:

- Staff are helpful and polite, irrespective of callers' telephone demeanor;
- Staff interactions with callers demonstrate an understanding and accommodation of the needs of HHSC clients (including clients with disabilities), the communication skills and comprehension levels of a diverse population, and a sound methodology for ensuring customer satisfaction and responsiveness;
- Staff treat each caller with dignity and respect;
- Staff greet callers and identify themselves by name and identification number when answering; and
- Staff are trained to deal with callers the MTO considers threatening or abusive.

2.34.5 *Frew* Consent Decree Requirements, ¶247 Equipment Failure

All calls will be answered promptly absent equipment failure.

HHSC interpretation of this measure is as follows: Promptness is addressed in the CAO: Toll Free Numbers, points A through E.

Equipment - Equipment includes all respondent owned, leased or contracted hardware and software that supports the processing of a call. This would include network connectivity, access to the database and equipment (operating within manufacturer's operating parameters).

Equipment Failure - Equipment failure would be an event that prohibits the functionality of the hardware or the software that supports the processing of a call. This would include network connectivity, access to the database and equipment (operating within manufacturer's operating parameters).

The MTO must report and notify HHSC of all outages, but it must adopt contingency and redundancy procedures so that resources for calls to the Client Toll-Free Line for transportation services from a caller requesting transportation services for a person with Medicaid from birth through age 20 calls are protected.

2.34.6 *Frew* Consent Decree Requirements, ¶247 Adequate Equipment

Equipment will be adequate so that failure results only from circumstances beyond the MTO's control, such as bad weather.

For those systems that could fail (or have failed in the past), or are considered critical to call center operations or to adherence of call center operations to *Frew* standards, the proposal must describe in detail the processes, equipment, and other resources the MTO will implement to ensure availability and continuity of services during any equipment outage. In the event that bad weather causes significant power outages or equipment failure, these are exempt. However, not all outages fall into this category, so processes, equipment and any other resources needed to ensure availability and continuity of services need to be in place and accessible, if needed, in order to maintain *Frew* standards.

2.34.7 *Frew* Consent Decree Requirements, ¶247 – Language

The MTO will make reasonable arrangements to meet the needs of clients who do not speak English.

MTO must adhere to Limited English Proficiency (LEP) requirements pursuant to Texas Administrative Code, Title 1, Part 15, Chapter 376, Subchapter B, Rule §376.221 -223. Further, due to the diverse nature of callers requesting transportation services for a person with Medicaid from birth through age 20, MTO must establish relations with over the phone translation vendor(s), to ensure accessibility to all languages.

2.34.8 *Frew* Consent Decree Requirements, ¶247 – Tape Recording

No calls may be “answered” by a tape recording during working hours except in unusual circumstances.

MTO cannot use a recorded device as the final point of destination for callers during business hours. While an interactive voice recognition (IVR) or auto-attendant may be used to answer the phone, all calls must continually have the option of reaching a live person, within the required standards, set forth in this section.

2.34.9 Frew *Consent* Decree and CAO: Toll Free Number Requirements: Reporting Requirements

As specified below, the MTO must submit the required reports exclusively for toll free line or to the Client Toll Free Line for transportation services.

HHSC may require additional reporting, related to compliance with Section 2.34 at any time, to ensure data integrity, accuracy or to track potential compliance. These reports could include hourly, daily, weekly or monthly reports and should be expected in the event of any non-compliance with these sections.

All report designs, formats and media re subject to HHSC approval. These reports can be submitted with the RFP response, but no later than ninety (90) days prior to the start of the readiness review.

2.34.10 *Frew* Consent Decree and CAO: Toll Free Number Requirements: Call Center Reporting Requirements

Within two business days after the end of each calendar month, the MTO must submit an electronic report that provides all the elements required by HHSC, exclusively to the Client Toll Free Line for transportation Services. This report is termed the MTO Monthly *Frew* Report. With this report, the MTO will include all trunks, IVR and Automatic Call Distribution (ACD) reports (along with any other reports) that substantiate and verify the information contained in the MTO Monthly *Frew* Report. All supporting reports will be electronic and in the format used by the respondent.

If any elements in the MTO Monthly *Frew* Report indicate non-compliance with call center standards, the MTO will provide daily interval reports for the day(s) that contributed to the non-compliance related to the performance measure(s) that were non-complaint. These daily interval reports are due with the Monthly *Frew* Report.

HHSC may request additional reporting, related to compliance with Section 2.34 at any time, to ensure data integrity, accuracy or to track potential compliance. These reports could include hourly, daily, weekly or monthly reports and should be expected in the event of any non-compliance with Section 2.34.

These reports must be submitted on an HHSC prescribed template and no later than 90 days prior to the start of the readiness review.

2.35 *Frew* CAO: Toll Free Number Requirements, Item A

Each call will be answered by a live person within a “maximum average” of 300 seconds, even if the call is initially answered by an interactive voice recognition (IVR) system or other equipment. The “maximum average” will be computed by adding the maximum waits in queue for each working day of the month and dividing by the number of working days.

2.35.1 CAO Interpretation

HHSC interpretation of this measure is as follows: For all calls received from a caller requesting transportation services for a person with Medicaid from birth through age 20 each day:

2.35.2 Wait Time

The MTO must track the length of the call that had the longest wait prior to speaking to a live person, each day. The wait time includes all time spent in the IVR (or auto-attendant) as well as the time waiting in queue.

2.35.3 Length of Call

The length of each daily call with the longest wait, prior to speaking to a live person for the month will be combined and divided by the total number of business days in the month. The resulting number must not exceed 300 seconds.

The MTO must explain how it will ensure and measure that each call from a caller requesting transportation services for a person with Medicaid from birth through age 20 is answered by a live person within a maximum average of 300 seconds using HHSC's interpretation of the requirement.

2.36 *Frew* CAO: Toll Free Number Requirements, Item B

The average monthly wait to speak to a live person after the IVR message and conclusion of user selection of menu items will not exceed 60 seconds.

HHSC interpretation of this measure is as follows: The average wait in queue, after the conclusion of the IVR or auto-attendant (including any menu selection) of all calls determined to be received from a caller requesting transportation services for a person with Medicaid from birth through age 20, during hours referenced in Section 2.3.10.1. Average is derived by dividing the total monthly time in queue for these calls by the number of answered calls for the month (placed by a caller requesting transportation services for a person with Medicaid from birth through age 20, during the hours specified in Section 2.3.10.1).

The MTO must explain how it will ensure and measure that the average monthly wait to speak to a live person after the IVR message and conclusion of the user selection menu will not exceed 60 seconds using HHSC's interpretation of the requirement, as provided above.

2.37 *Frew* CAO: Toll Free Number Requirements, Item C

The maximum abandonment rate each month will not exceed 10%.

HHSC interpretation of this measure is as follows: The percentage of calls received from a caller requesting transportation services for a person with Medicaid from birth through age 20, during each month that are abandoned, after conclusion of any IVR (or auto-attendant) selections, determined to be placed by a caller requesting transportation services for a person with Medicaid from birth through age 20, during hours referenced

in Section 2.3.10.1. The monthly total for this measure is divided into the monthly total calls received, after conclusion of any IVR (or auto-attendant) selections, determined to be placed by a caller requesting transportation services for a person with Medicaid from birth through age 20, during hours referenced in Section 2.3.10.1HHSC considers the word “maximum” in the Court document(s) referring to this measure as extraneous.

The MTO must explain how it will ensure and measure that the maximum abandonment rate each month will not exceed 10% using HHSC’s interpretation of the requirement.

2.38 *Frew* CAO: Toll Free Number Requirements, Item D

No more than 2% of calls will be “answered” by busy signals, disconnections, or other technical problems that prevent the caller from receiving help from staff.

HHSC interpretation of this measure is as follows: This standard starts at the point where the call reaches the toll free number platform. HHSC contracts with telecommunications providers for toll free number services. This standard applies from the point at which the call reaches the toll free number platform to the point at which the call is answered by a live operator. It applies to all calls determined to be placed by a caller requesting transportation services for a person with Medicaid from birth through age 20, during the hours referenced in Section 2.3.10.1.

The MTO must explain how it will measure and ensure that no more than 2% of calls will be answered by busy signals, disconnection or other technical problems using HHSC’s interpretation of the requirement.

2.39 *Frew* CAO: Toll Free Number Requirements, Item E

No calls will be “answered” by “clearing the queue” (i.e., “answering” only to ask callers to call back later or to tell callers staff will contact them later).

HHSC interpretation of this measure is as follows: For calls determined to be placed by a caller requesting transportation services for a person with Medicaid from birth through age 20, during hours referenced in Section 2.3.10.1, staff (or equipment) are prohibited from answering a call and subsequently 1) asking callers to call back later, 2) informing caller that staff will contact them later, 3) disconnecting the call, or 4) taking some other similar action to shorten the call, short of scheduling the services requested. However, there are some circumstances; that may warrant a call back from staff. Examples include situations where it is not feasible to complete the scheduling of a service during a single call (e.g., reservations for air travel) or when the MTO needs to research the status of certain services (e.g., mileage reimbursements). In these instances, call backs from staff are allowable as long as a normal call flow is followed and the request is pursued as much as possible on the initial call.

If the MTO intends to place calls on hold, or otherwise keep the phone line open with the caller, while issues such as those listed above are handled, the MTO needs to specify this in the response. The MTO should also indicate how it will determine which calls need to conform to this standard and which fall outside. If technology is to be used to determine if any of these forbidden activities occurred, the MTO needs to include the specific data definitions that will be utilized and how the MTO will interpret those results.

The MTO must explain how it will ensure and measure that no calls will be “answered” by clearing the queue.

2.39.1 *Frew* Consent Decree Requirements, ¶243

The toll free numbers to request transportation and scheduling assistance will either be combined or linked. When clients call to ask for help with transportation, they will also be able to get help with scheduling (or vice versa). This system will be more hospitable and helpful to clients than the past system.

HHSC interpretation of this measure is as follows: For each call placed by a caller requesting transportation services for a person with Medicaid from birth through age 20, during hours referenced in Section 2.3.10.1. MTO staff will transfer the caller to the THSteps toll free line, when the caller requests assistance with finding a provider or scheduling appointments with a provider. This transfer can be performed without waiting for THSteps staff or equipment to answer before releasing the line. However, callers must be made aware of the transfer, it should be made at the appropriate point in the call (i.e., if the caller already has some appointments and requires transportation assistance, that should be addressed before transferring to THSteps, for help with scheduling additional appointments with provider(s)). The caller should also be given the THSteps number prior to the transfer, in case the caller needs to contact THSteps again.

In conjunction with their response the MTO must explain how they will ensure this requirement is met by staff. The MTO must also propose reporting necessary to demonstrate compliance with this requirement as a part of their response.

2.40 *Frew* Recordkeeping and Record Retention

The MTO must maintain, and require its Performing Providers to maintain, all documents related to *Frew* class members. Records must be maintained until the MTO receives written authorization from HHSC that such records may be destroyed. The term document is broad and encompasses the original and any draft or non-identical copy of any document, including exhibits and attachments. The term document also includes any method of reducing or recording information in written form, including but not limited to, a memo, letter, note, post-it, drawings, graphs, charts, emails, electronic or videotape recordings, digital signatures, computer disks, tapes or other forms of computer memory storage, and other data compilations.

Hard copy documents can be stored in a more convenient form (e.g., scanned computer image, microfiche). Provided the document in the new medium is clearly decipherable and an exact duplicate (other than its medium of storage), the original hard copy does not need to be retained. Records maintained by former employees must be retained upon the employee’s departure. Documents must not be destroyed as long as the lawsuit is still pending. All data and record documents must be released to HHSC at the termination of the contract.

2.41 Cost Saving

A goal of this procurement is to obtain cost savings. Respondent must attempt to identify and propose strategies and measures that reduce the cost to HHSC of NEMT within their response.

2.42 Ability to Perform

MTO warrants that it has the financial resources to fund the capital expenditures required under the Contract without advances by HHSC or assignment of any payments by HHSC to a financing source.

3. General Instructions and Proposal Requirements

3.1 Vendor Conference

HHSC will hold a vendor conference on December 10, 2013 at the John H. Winters Bldg., Public Hearing, Rooms 125E, 125W and 125C, 701 West 51st Street, Austin, Texas 78751. Vendor conference attendance is strongly recommended, but is not required.

Respondents may email questions for the conference to the HHSC Point of Contact (see Section 1.2) no later than five (5) days before the conference for potential responses at the conference. HHSC will also give respondents the opportunity to submit written questions at the conference. All questions should reference the appropriate RFP page and section number. HHSC will post appropriate information regarding the RFP on the Electronic State Business Daily. HHSC will attempt to respond to questions at the vendor conference, but responses are not official until posted in final form on the HHSC website. HHSC reserves the right to amend answers prior to the proposal submission deadline.

3.2 Questions and Comments

All questions and comments regarding this RFP should be sent to the HHSC Point of Contact (see Section 1.2). Questions must reference the appropriate RFP page and section number and must be submitted by the deadline set forth in Section 1.3 HHSC will not respond to questions received after the deadline. HHSC will post appropriate information regarding the RFP on the Electronic State Business Daily and HHSC's responses to vendor questions will be posted to the HHSC website. HHSC reserves the right to amend answers prior to the proposal submission deadline.

Respondents must notify HHSC of any ambiguity, conflict, discrepancy, exclusionary specification, omission or other error in the RFP by the deadline for submitting questions and comments. If a respondent fails to notify HHSC of these issues, it will submit a proposal at its own risk and if awarded a contract: (1) shall have waived any claim of error or ambiguity in the RFP or resulting contract; (2) shall not contest HHSC's interpretation of such provision(s); and (3) shall not be entitled to additional compensation, relief or time by reason of the ambiguity, error or its later correction.

3.3 Modification or Withdrawal of Proposal

Prior to the proposal submission deadline set forth in Section 3.16.1.2, a respondent may: (1) withdraw its proposal by submitting a written request to the HHSC Point of Contact; or (2) modify its proposal by submitting a written amendment to the HHSC Point of Contact. HHSC may request proposal modifications at any time.

HHSC reserves the right to waive minor informalities in a proposal and award a contract that is in the best interest of the State of Texas. A “minor informality” is an omission or error that, in HHSC’s determination, if waived or modified when evaluating proposals, would not give a respondent an unfair advantage over other respondents or result in a material change in the proposal or RFP requirements. When HHSC determines that a proposal contains a minor informality, it may at its discretion, provide the respondent with the opportunity to correct it.

3.4 News Releases

Prior to tentative award, a vendor may not issue a press release or provide any information for public consumption regarding its participation in the procurement. After tentative award, a vendor must receive prior written approval from HHSC before issuing a press release or providing information for public consumption regarding its participation in the procurement. Requests should be directed to the HHSC Point of Contact identified in Section 1.2. Failure to comply with this requirement may be cause for breach of contract and will be strictly enforced by HHSC.

This Section does not preclude business communications necessary for a vendor to develop a proposal or required reporting to shareholders or governmental authorities.

3.5 Incomplete Proposals

HHSC may reject without further consideration a proposal that does not include a complete, comprehensive or total solution as requested by the RFP.

3.6 State Use of Ideas

HHSC reserves the right to use any and all ideas presented in a proposal unless the respondent presents a written valid legal case that such ideas are trade secret or confidential information and identifies the information as such in its proposal. A respondent may not object to the use of ideas that are not the respondent’s intellectual property and so designated in the proposal that: (1) were known to HHSC before the submission of the proposal; (2) were in the public domain through no fault of HHSC; or (3) became properly known to HHSC after proposal submission through other sources or through acceptance of the proposal.

3.7 Property of HHSC

Except as otherwise provided in this RFP or the resulting contract, all products produced by a respondent, including without limitations the proposal, all plans, designs, software and other contract deliverables, become the sole property of HHSC.

3.8 Copyright Restriction

HHSC will not consider any proposal that bears a copyright.

3.9 Additional Information

By submitting a proposal, the respondent grants HHSC the right to obtain information from any lawful source regarding the respondent's and its directors', officers', and employees': (1) past business history, practices, and conduct; (2) ability to supply the goods and services; and (3) ability to comply with contract requirements. By submitting a proposal, a respondent generally releases from liability and waives all claims against any party providing HHSC information about the respondent. HHSC may take such information into consideration in evaluating proposals.

3.10 Multiple Responses

Respondents may not submit multiple proposal responses for a given MTO Region. Respondents may apply for multiple MTO Regions; if so, they must a separate proposal response for each MTO Region in which they are interested. Each proposal must be separately marked and must offer a complete solution in accordance with the RFP requirements.

3.11 No Joint Proposals

HHSC will not consider joint or collaborative proposals that require the agency to contract with more than one respondent.

3.12 Use of Performing Providers

Performing Providers providing services under the contract shall meet the same requirements and level of experience as required of the respondent. No subcontract under the contract shall relieve the respondent of the responsibility for ensuring the requested services are provided. Respondents planning to subcontract all or a portion of the work to be performed shall identify the proposed Performing Providers.

3.13 Material Subcontract Information

Organize this information by Material Subcontractor, and list them in descending order of estimated annual payments.

3.13.1 Material Subcontractor

For each Material Subcontractor, the MTO must provide:

3.13.1.1 The Material Subcontractor's legal name, trade name, acronym, d.b.a., and any other name under which the Material Subcontractor does business.

3.13.1.2 The Respondent's estimated annual payments to the Material Subcontractor's.

3.13.1.3 The physical address, mailing address, and telephone number of the Material Subcontractor's headquarters office, and the name of its Chief Executive Officer.

3.13.1.4 Whether the Material Subcontractor's is an Affiliate of the Respondent or an unrelated third party.

3.13.1.5 Federal taxpayer identification number.

3.13.1.6 The website address (URL) for the homepage of any website operated, owned, or controlled by the Material Subcontractor, including any websites run by another entity on the Material Subcontractor's behalf. If the Material Subcontractor has a parent, then also provide the same for the parent organization, and any parent of the parent organization. If none exist, provide a clear and definitive statement to this effect.

3.13.2 Information about Material Subcontractors

3.13.2.1 A description of each Material Subcontractor's corporate background and experience, including its estimated annual revenues from unaffiliated parties, number of employees, location(s), and identification of three (3) major clients.

3.13.2.2 A signed letter of commitment from each Material Subcontractor that states the Material Subcontractor's willingness to enter into a subcontract agreement with the Respondent, and a statement of work for subcontracted activities. Letters of Commitment must be provided on the Material Subcontractor's official company letterhead, signed by an official with the authority to bind the company for the subcontracted work. The Letter of Commitment must state, if applicable, the company's certified HUB status.

3.13.2.3 The business entity structure of the Material Subcontractor and the Affiliate. [For example, wholly-owned subsidiary of a publicly-traded corporation; wholly-owned subsidiary of a private (closely-held) stock corporation; subsidiary or component of a non-profit foundation; subsidiary or component of a governmental entity; independently-owned member of an alliance or cooperative network; joint venture (describe owners)]. Indicate the name of the ultimate owner (e.g., the name of a publicly-traded corporation or a County government).

3.13.2.4 Indicate status (all that may apply): sole proprietor, partnership, corporation, for-profit, non-profit, privately owned, or listed on a stock exchange. If a Subsidiary or Affiliate, name of the direct and ultimate parent organization.

3.13.2.5 The name and address of any sponsoring corporation or others who provide financial support to the Material Subcontractor, and

the type of support, e.g., guarantees, letters of credit. Indicate if there are maximum limits of the additional financial support.

3.13.2.6 The state in which the Material Subcontractor is incorporated, commercially domiciled, and the states in which the organization is licensed to do business.

3.13.3 Material Subcontractor is an Affiliate

If the Material Subcontractor is an Affiliate, then also provide:

3.13.3.1 The name of the Material Subcontractor's parent organization, and the Material Subcontractor's relationship to the Respondent.

3.13.3.2 The proportion, if any, of the Material Subcontractor's total revenues that are received from non-Affiliates. If the Material Subcontractor has significant revenues from non-Affiliates, then also indicate the portion, if any, of those external (non-Affiliate) revenues that are for services similar to those that the Respondent would procure under the proposed Subcontract.

3.13.3.3 A description of the proposed method of pricing under the Subcontract.

3.13.3.4 Indicate if the Respondent presently procures, or has ever procured, similar services from a non-Affiliate.

3.13.3.5 The number of employees (staff and management) who are dedicated full-time to the Affiliate's business.

3.13.3.6 Whether the Affiliate's office facilities are completely separate from the Respondent and the Respondent's parent. Identify the approximate number of square feet of office space that are dedicated solely to the Affiliate's business.

3.13.3.7 Attach an organization chart for the Affiliate, showing head count, Key Personnel names, titles, and locations.

3.13.3.8 Indicate if the staff and management of the Affiliate are directly employed by the Affiliate itself, or are they legally employed by a different legal entity (such as a parent corporation). The employee's W-2 form identifies the name of the corporation and is indicative of the actual employer.

3.14 Texas Public Information Act

3.14.1 General Requirement for the Release of Proposals

Proposals will be subject to the Texas Public Information Act (the Act), located in Chapter 552 of the Texas Government Code, and may be disclosed to the public upon

request. Subject to the Act, respondents may protect trade secret and confidential information from public release. If the respondent asserts that information provided in the proposal is trade secrets or other confidential information, it must be clearly marked such information in boldface type and include the words "confidential" or "trade secret" at top of the page. Furthermore, the respondent must identify trade secret or confidential information, and provide an explanation of why the information is excepted from public disclosure, on the Respondent Information and Disclosures form.

Successful respondent is required to make any information created or exchanged with the state pursuant to any contract resulting from this RFP, and not otherwise excepted from disclosure under the Texas Public Information Act, available in a format that is accessible by the public at no additional charge to the state.

HHSC will process any request from a member of the public in accordance with the procedures outlined in the Act. Respondents should consult the Texas Attorney General's website (www.oag.state.tx.us) for information concerning the Act's application to proposals and potential exceptions to disclosure.

3.15 Publication of Major Contracts

Texas Government Code §322.020 requires HHSC to provide copies of "major contracts" to the Legislative Budget Board (LBB). If the contract resulting from this procurement falls within the §322.020 definition of a "major contract," the LBB will provide the public with access to all contract documents. This includes the proposal, unless the respondent can demonstrate that all or part of the proposal is excepted from disclosure under the Texas Public Information Act. In such cases, the respondent will be responsible for preparing, for HHSC's approval, an appendix that describes the exempt information contained in the proposal without disclosing its content, as required by Texas Government Code §322.020 (d).

3.16 General Instructions and Proposal Requirements

3.16.1 Instructions for Submitting Proposals

3.16.1.1 Number of Copies

Submit one (1) original and twelve (12) copies of the proposal. An authorized representative must sign the original in ink. In addition, submit one electronic copy of the proposal on a portable media, such as a compact disk, compatible with Microsoft Office 2010, PDF format is not allowed. HHSC will not accept telephone and facsimile proposals. Any disparities between the contents of the original printed proposal and the electronic proposal will be interpreted in favor of HHSC.

3.16.1.2 Submission

Submit all copies of the proposal to HHSC's Procurement and Contracting Services (PCS) Division no later than **2:00 p.m.** CST on **January 10, 2014.** All submissions will be date and time stamped when received by PCS. The clock in the PCS office is the official timepiece for determining compliance with the deadlines in this procurement.

HHSC reserves the right to reject late submissions. It is the respondent's responsibility to appropriately mark and deliver the proposal to HHSC by the specified date.

3.16.1.3 Physical Address for hand delivery and overnight and commercial mail:

HHSC Procurement and Contracting Services (PCS) Division
Attn: Robert Hall, C.P.M., CTPM, CCA
Procurement and Contracting Services
Texas Health and Human Services Commission
4405 N Lamar Blvd.
Austin, Texas 78756

All proposals become the property of HHSC after submission.

3.16.1.4 Additional Requirements:

All proposals must be:

- clearly legible;
- sequentially page-numbered and include the respondent's name at the top of each page;
- organized in the sequence outlined in Section 3.17.1;
- bound in a notebook or cover;
- correctly identified with the RFP number and submittal deadline;
- responsive to all RFP requirements;
- typed on 8½ by 11" paper;
- in Arial or Times New Roman font, size 12 for normal text, no less than size 10 for tables, graphs and appendices; and
- no more than 100 total pages, double-sided, excluding required forms, resumes, financial data and financial reports.

Proposals may not include materials or pamphlets not specifically requested in this RFP.

3.17 Format and Content

The proposal must consist of the following parts:

- Part 1 – Business Proposal
- Part 2 – Provider Identification
- Part 3 – Technical Proposal

3.17.1 Part 1 – Business Proposal

The Business Proposal must include the following sections:

- Section 1 – Executive Summary (See 3.17.1.1 below)
- Section 2 – Corporate Background and Experience (See 3.17.1.2 below)

- Section 3 – Project Work Plan (See 3.17.1.3 below)
- Section 4 – Assumptions (See 3. 17.1.4 below)
- Section 5 – Appendices (See 3.17.1.5 below)
- Section 6 – HUB Subcontracting Plan, if applicable (See 3.17.1.6 below)
- Section 7 – Certifications and Other Required Forms (See 3.17.1.7 below)

3.17.1.1 Executive Summary

In this section, condense and highlight the content of the Business Proposal to provide HHSC with a broad understanding of the respondent's approach to meeting the RFP's business requirements. The summary must demonstrate an understanding of HHSC's goals and objectives for this procurement.

3.17.1.2 Corporate Background and Experience

This section details the respondent's corporate background and experience. If the respondent proposes to use Performing provider(s), it must describe any existing or ongoing relationships with the Performing provider(s), including project descriptions. The section should include the following information:

3.17.1.2.1 Corporate Background and Experience

3.17.1.2.1.1 Describe the respondent's corporate background as it relates to projects similar in scope and complexity to the project described in this RFP.

3.17.1.2.1.2 Include a description and at least three (3) references from projects performed within the last five (5) years that demonstrate the respondent's ability to perform the Scope of Work described in the RFP. Include contract dates and contact information (customer points of contact, address, telephone number and email address). The respondent must explain whether it performed the work as a prime contractor or Performing provider. If the respondent performed the work as a Performing provider, the respondent must describe the scope of subcontracted activities.

3.17.1.2.1.3 With respect to the Respondent and its parent (and including other nonemergency transportation subsidiaries of the parent), briefly describe any regulatory actions, sanctions, or fines imposed by any federal or Texas regulatory entity, or a regulatory entity in another state, within the last three years. Include a description of any letters of deficiencies, corrective actions, findings of non-compliance, or sanctions. HHSC may, at its option, contact these clients or regulatory agencies and any other individual or organization whether or not identified by the Respondent.

3.17.1.2.2 Résumés

3.17.1.2.2.1 Identify and describe the respondent's and its Performing provider's proposed labor skill set and provide résumés of all proposed key personnel (as defined by the respondent). Résumés must demonstrate experience germane to the position proposed. Résumés should include work on projects cited under the respondent's corporate experience, and the specific functions performed on such projects. Each résumé should include at least three (3) references from recent projects. References may not be the respondent's or Performing provider's employees.

3.17.1.2.3 Financial Capacity and Corporate Guarantee

Submit the following financial documents to demonstrate the Respondent's financial solvency, and its capacity to comply with the financial requirements of the RFP and Contract, including the "Contract Terms and Conditions":

Audited Financial Statements covering the two (2) most recent years of the Respondent's financial results. These statements must include the independent auditor's report (audit opinion letter to the Board or shareholders), the notes to the financial statements, any written description of legal issues or contingencies, and any management discussion or analysis.

Make sure that the name and address of the firm that audits the Respondent is shown. State the date of the most-recent audit, and whether the Respondent is audited annually or otherwise. State definitively if there has, or has not, been any of the following:

- a "going concern" statement was issued by any auditor in the last three (3) years;
- a qualified opinion was issued by any auditor in the last three (3) years;
- a change of audit firms in the last three (3) years; and
- any significant delay (2 months or more) in completing the current audit.

The Respondent must state definitively as to whether the Respondent files reports with the Texas Department of Insurance (TDI) or is subject to examination by TDI. If the Respondent does or has filed any reports with, or been examined by, TDI, then the Respondent must furnish along with the RFP full and complete copies of any of the following which may exist:

a) The most recent quarterly and annual financial statements filed with the TDI, and if the Respondent is domiciled in another state, the financial statements filed with the state insurance department in its state of domicile. The annual financial statement must include all schedules, attachments, supplements, management discussion, analysis, and actuarial opinions.

b) The most recent financial examination report issued by TDI, and by any state insurance department in states where the Respondent operates a Medicaid or comparable managed care product. If any submitted financial examination report is two (2) or more years old, or if Respondent has never had a financial examination report issued, submit the anticipated approximate date of the next issuance of a TDI or state department of insurance financial examination report.

c) The most recent Form B Registration Statement disclosure filed by Respondent with TDI, and any similar form filed with any state insurance department in other states where the Respondent operates a Medicaid or comparable managed care product. If Respondent is exempt from the TDI Form B filing requirement, Respondent must state that this is not applicable.

Other related documents, as applicable:

a) SEC Form 10-K and 10-Q. If Respondent or its parent is a publicly-traded (stock-exchange-listed) corporation, then submit the most recent United States Securities and Exchange Commission (SEC) Form 10-K Annual Report, and the most-recent 10-Q Quarterly report.

b) IRS Form 990. If the Respondent or its parent is a non-profit entity, then submit the most recent annual Internal Revenue Service (IRS) Form 990 filing, complete with all attachments or schedules. If Respondent is a non-profit entity that is exempt from the IRS 990 filing requirement, demonstrate this and explain the nature of the exemption.

c) If the Respondent is a non-profit entity that is a component or subsidiary of a County government, or otherwise an entity of a government, then submit the most recent annual financial statements as prepared under the relevant rules or statutes governing annual financial reporting and disclosure for Respondent, including all attachments, schedules, and supplements.

d) Bond or debt rating analysis. If Respondent or its parent has been, in the last 3 years, the subject of any bond rating analysis, ratings affirmation, write-up, or related report, such as by AM Best, Fitch Ratings, Moody's, Standard & Poor, submit the most-recent detailed report from each rating entity that has produced such a report.

e) Annual Report. If Respondent or its parent produces any written "annual report" or similar item that is in addition to the above-referenced documents, submit the most recent version. This might be a yearly report or letter to shareholders, the community, regulators, lenders, customers, employees, the Respondent's owner, or other constituents.

f) If the Respondent or its parent has issued any press releases in the 12 months prior to the submission due date, and the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or losses, penalties/fines/sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues, provide a copy of each the press release. HHSC does not wish to receive other types of press releases that are primarily promotional in nature.

With respect to items 3(a) through 3(e), Respondent must also submit a schedule that shows for each of the five categories: whether there is any applicable filing or report; the name(s) of the entity that does the filing or report; and the regular or estimated filing/distribution date(s).

At a minimum, the financial statements and reports submitted must include:

1. balance sheet;
2. statement of income and expense;
3. statement of cash flows;
4. statement of changes in financial position (capital & surplus; equity);
5. independent auditor's letter of opinion;
6. description of organization and operation, including ownership, markets served, type of entity, number of locations and employees, and, dollar amount and type of any Respondent business outside of that with HHSC; and
7. disclosure of any material contingencies, and any current, recent past, or known potential material litigation, regulatory proceedings, legal matters, or similar issues.

The Respondent must include key non-financial metrics and descriptions, such as facilities, number of covered lives, area of geographic coverage, years in business, material changes in business situation, key risks, and prospective issues.

3.17.1.2.4 Financial Report of Parent Organization and Corporate Guarantee

If another corporation or entity either substantially or wholly owns the Respondent, submit the most recent detailed financial reports (as required above) for the parent organization. If there are one or more intermediate owners between the Respondent and the ultimate owner, this additional requirement is applicable only to the ultimate owner.

The Respondent must also include a statement that the parent organization will unconditionally guarantee performance by the Respondent of each and every obligation, warranty, covenant, term and condition of the Contract. This guarantee is not required for Respondents owned by political subdivisions of the State (e.g., county governments).

If HHSC determines that an entity does not have sufficient financial resources to guarantee the Respondent's performance, HHSC may require the Respondent to obtain another acceptable financial instrument or resource from such entity, or to obtain an

acceptable guarantee from another entity with sufficient financial resources to guarantee performance.

3.17.1.2.5 Bonding

HHSC reserves the right to require the respondent to procure one or more performance, fidelity, payment or other bond, if during the term of the contract; HHSC in its sole discretion determines that there is a business need for such requirement.

The Respondent must submit a statement that, if selected as a Contractor, the Respondent agrees to secure and maintain throughout the life of the Contract, fidelity bonds required by the Texas Department of Insurance in compliance with Texas Insurance Code §843.402, and secure and maintain throughout the life of the Contract, a performance bond in accordance with the Uniform Contract Terms and Conditions of this RFP and Texas Administrative Code, Title 28, Part 1, Chapter 11, Subchapter S, Rule §11.1805.

3.17.1.3 Project Work Plan

Fully describe the respondent's proposed processes and methodologies for providing all components of the Mission, Mission Objectives, Scope of Work described in Section 2 and Section 6, including the respondent's approach to meeting the Project Schedule. Each proposal must incorporate plans to meet the *Frew* obligations. Summaries or a statement that you will provide the requirements of the scope of work is insufficient. A complete and detailed explanation of how you will meet every requirement contained in this RFP is required. Plans lacking detail of means and methods will be less favorably evaluated.

3.17.1.4 Assumptions

State any business, economic, legal, programmatic, or practical assumptions that underlie the respondent's response to the Business Proposal. HHSC reserves the right to accept or reject any assumptions. All assumptions not expressly identified and incorporated into the contract resulting from this RFP are deemed rejected by HHSC.

3.17.1.5 Appendices

Respondents are not required to submit appendices to the Business Proposal.

3.17.1.6 HUB Subcontracting Plan

Attach the respondent's Historically Underutilized Business (HUB) Subcontracting Plan. Instructions for completing this section are in Article 4 of the RFP.

3.17.1.7 Certifications and Other Required Forms

Respondents must submit the following required forms with their proposals:

- Child Support Certification;

- Debarment, Suspension, Ineligibility, and Voluntary Exclusion of Covered Contracts;
- Federal Lobbying Certification;
- Nondisclosure Statement;
- Required Certifications; and
- Respondent Information and Disclosures.

The required forms are located on HHSC's website, under the "Business Opportunities" link. HHSC encourages respondents to carefully review all of these forms and submit questions regarding their completion prior to the deadline for submitting questions (see Section 1.3).

3.17.2 Part 2 – Respondent Identification

3.17.2.1 Respondent Identification and Information

3.17.2.1.1 Respondent identification and basic information.

The Respondent's legal name, trade name, d/b/a, acronym, and any other name under which the Respondent does business.

The physical address, mailing address, and telephone number of the Respondent's headquarters office.

3.17.2.2 Respondent Legal Status and Ownership.

3.17.2.2.1 The type of ownership of the Respondent by its ultimate parent:

- wholly-owned subsidiary of a publicly-traded corporation;
- wholly-owned subsidiary of a private (closely-held) stock corporation;
- subsidiary or component of a non-profit foundation;
- subsidiary or component of a governmental entity;
- independently-owned member of an alliance or cooperative network;
- joint venture (describe ultimate owners);
- stand-alone privately-owned corporation (no parents or subsidiaries); or
- other (describe)

3.17.2.2.2 The legal status of the Respondent and its parent (any/all that may apply):

- Respondent is a corporation, partnership, sole proprietor, or other (describe);
- Respondent is for-profit, or non-profit;

- the Respondent's ultimate parent is for-profit, or non-profit;
- the Respondent's ultimate parent is privately-owned, listed on a stock exchange, a component of government, or other (describe).

3.17.2.2.3 The legal name of the Respondent's ultimate parent (e.g., the name of a publicly-traded corporation, or a County governmental entity).

3.17.2.2.4 The name and address of any other sponsoring corporation, or others (excluding the Respondent's parent) who provide financial support to the Respondent, and the type of support, e.g., guarantees, letters of credit. Indicate if there are maximum limits of the additional financial support.

3.17.2.2.5 The full names and titles of the Respondent's officers and directors.

3.17.2.2.6 If any change of ownership of the Respondent's company or its parent is anticipated during the twelve months following the Proposal Due Date, the Respondent must describe the circumstances of such change and indicate when the change is likely to occur.

3.17.2.2.7 The website address (URL) for the homepage of any website operated, owned, or controlled by the Respondent, including any that the Respondent may have contracted to be run by another entity. If the Respondent has a parent, then also provide the same for the parent, and any parent of the parent. If none exists, provide a clear and definitive statement to that effect.

3.17.3 Part 3 – Technical Proposal

Respondents must provide a detailed description of the proposed technical solution, which must support all business activities and requirements described in the RFP. The Technical Proposal must reflect a clear understanding of the nature of the work undertaken, and must include a detailed descriptions of the proposed system(s).

The Technical Proposal must include a description of the following system components, at a minimum:

- Section 1 – Technology Architecture (See 3.17.3.1 below)
- Section 2 – Capacity Management and System Availability (See 3.17.3.2 below)
- Section 3 – Software and Hardware Components (See 3.17.3.3 below)
- Section 4 – Systems Integration (See 3.17.3.4 below)

- Section 5 – System Administration, Support, and Maintenance (See 3.17.3.5 below)
- Section 6 – System Security and Disaster Recovery (See 3.17.3.6 below)
- Section 7 – Performance Monitoring and Management (See 3.17.3.7 below)
- Section 8 – Value-added Benefits (See 3.17.3.8 below)
- Section 9 – Assumptions (See 3.17.3.9 below)
- Section 10 – Appendices (See 3.17.3.10 below)

3.17.3.1 Technology Architecture

Provide a detailed description of the proposed technology architecture and include one or more diagrams that detail the relationships between key technical components.

3.17.3.2 Capacity Management and System Availability

The respondent is responsible for delivering a cost-effective, high-availability environment that minimizes the frequency and impact of system failures, reduces downtime, and minimizes recovery time in the event of catastrophic failure. In this section, provide details on the respondent's approach to providing a highly available system. In addition, provide details on the proposed approach to monitoring system performance and use and planning, sizing and controlling the system as capacity needs change.

3.17.3.3 Software and Hardware Components

Provide details on the software and hardware components the respondent proposes to use in its system. This includes, but is not limited to, the proposed server topology, specifications for the hardware components, and data storage components. The respondent should also include details on the tools and utilities used to design, build, test, deploy, report, monitor, and operate the system and its components.

3.17.3.4 Systems Integration

Describe the respondent's approach to integrating the proposed system with other information systems.

3.17.3.5 System Administration, Support, and Maintenance

Detail the respondent's approach to administering the system and system components. Detail the proposed approach to system support, including the levels of support offered and the process for requesting support. In addition, provide a summary of the respondent's proposed strategy for maintaining and repairing the system.

3.17.3.6 System Security and Disaster Recovery

Detail on the respondent's approach to security architecture, including the development and implementation measures that will provide security and protection for the system. Describe the proposed backup and recovery processing approach, and proposed virus

protection strategy. Describe the respondent's general approach to reestablishing operations in the event of a catastrophe, as well as its approach to providing HHSC with a disaster recovery plan. Provide specifications on any hardware and software components utilized by the proposed security and disaster recovery solutions.

3.17.3.7 Performance Monitoring and Management

Describe the respondent's proposed methodology for monitoring and reporting system performance, as well as the respondent's proposed approach to technology management. This includes the methods for centrally managing system resources such as servers, backup, archiving, and recovery equipment, databases and applications. Address methods for auditing, tracing and scanning the system. Provide details on the use of specialized tools the respondent will use to automate and track monitoring and management activities.

3.17.3.8 Value-added Benefits

Describe any enhancements or additions to the system that are not required by the RFP that the respondent proposes to provide at no additional cost to HHSC. Respondents are not required to proposed Value-added benefits, but inclusion of such benefits may result in a more favorable evaluation.

3.17.3.9 Assumptions

State any business, economic, legal, programmatic, or practical assumptions that underlie the respondent's response to the Technical Proposal. HHSC reserves the right to accept or reject any assumptions. All assumptions not expressly identified and incorporated into the contract resulting from this RFP are deemed rejected by HHSC.

3.17.3.10 Appendices

Respondents are not required to submit appendices to the Technical Proposal.

4. Historically Underutilized Business Participation

In accordance with Texas Government Code §2161.252, a proposal that does not contain a HUB Subcontracting Plan (HSP) is non-responsive and will be rejected without further evaluation. In addition**, if HHSC determines that the HSP was not developed in good faith, it will reject the proposal for failing to comply with material RFP specifications.**

4.1 Introduction

HHSC is committed to promoting full and equal business opportunities for businesses in state contracting in accordance with the goals specified in the State of Texas Disparity Study. HHSC encourages the use of Historically Underutilized Businesses (HUBs) through race, ethnic and gender-neutral means. HHSC has adopted administrative rules relating to HUBs, and a Policy on the Utilization of HUBs, which is located on HHSC's website.

Pursuant to Texas Government Code §2161.181 and §2161.182, and HHSC's HUB policy and rules, HHSC is required to make a good faith effort to increase HUB participation in its contracts. HHSC may accomplish the goal of increased HUB participation by contracting directly with HUBs or indirectly through subcontracting opportunities.

4.2 HHSC's Administrative Rules

HHSC has adopted the CPA's HUB rules as its own. HHSC's rules are located in the Texas Administrative Code Title 1, Part 15, Chapter 392, Subchapter J, and the CPA rules are located in Texas Administrative Code, Title 34, Part 1, Chapter 20, Subchapter B. If there are any discrepancies between HHSC's administrative rules and this RFP, the rules shall take priority.

4.3 Statewide Annual HUB Utilization Goal

The CPA has established **statewide annual HUB utilization goals** for different categories of contracts in Texas Administrative Code, Title 34, Part 1, Chapter 20, Subchapter B, §20.13 of the HUB Rules. In order to meet or exceed the **statewide annual HUB utilization goals**, HHSC encourages outreach to certified HUBs. Contractors shall make a good faith effort to include certified HUBs in the procurement process.

This procurement is classified as an **All Other Services** procurement under the CPA rule, and therefore has a **statewide annual HUB utilization goal** of **24.6%** per fiscal year.

4.4 Required HUB Subcontracting Plan

In accordance with Texas Government Code, Chapter 2161, Subchapter F, each state agency that considers entering into a contract with an expected value of $100,000 or more over the life of the contract (including any renewals) shall, before the agency solicits bids, proposals, offers, or other applicable expressions of interest, determine whether subcontracting opportunities are probable under the contract.

In accordance with Title 34, Part 1, Chapter 20, Subchapter B, Rule §20.14(a)(1)(C), of the HUB Rule, state agencies may determine that subcontracting is probable for only a subset of the work expected to be performed or the funds to be expended under the contract. If an agency determines that subcontracting is probable on only a portion of a contract, it shall document its reasons in writing for the procurement file.

HHSC has determined that subcontracting opportunities are probable for this RFP. As a result, the respondent must submit an HSP with its proposal. The HSP is required whether a respondent intends to subcontract or not.

In the HSP, a respondent must indicate whether it is a Texas certified HUB. Being a certified HUB does not exempt a respondent from completing the HSP requirement.

HHSC shall review the documentation submitted by the respondent to determine if a good faith effort has been made in accordance with solicitation and HSP requirements. During the good faith effort evaluation, HHSC may, at its discretion allow revisions necessary to clarify and enhance information submitted in the original HSP.

If HHSC determines that the respondent's HSP was not developed in good faith, the HSP will be considered non-responsive and will be rejected as a material failure to comply with advertised specifications. The reasons for rejection shall be recorded in the procurement file.

4.5 CPA Centralized Master Bidders List

Respondents may search for HUB subcontractors in the CPA's Centralized Master Bidders List (CMBL) HUB Directory, which is located on the CPA's website at http://www2.cpa.state.tx.us/cmbl/cmblhub.html. For this procurement, HHSC has identified the following class and item codes for potential subcontracting opportunities:

National Institute of Governmental Purchasing (NIGP) Class/Item Code:

- **Class 948 - Item 07:** Administration Services, Health
- **Class 952 - Item 59:** Human Services (Not Otherwise Classified)
- **Class 952 - Item 94:** Transportation Services for Elderly, Handicapped, Incapacitated, Prisoners, Juries, etc.
- **Class 961 - Item 82**: Transportation Services (Not Otherwise Classified)
- **Class 915 - Item 49:** High Volume, Telephone Call Answering Services (See 915-05 for low volume Services)
- **Class 918 - Item 96:** Transportation Consulting
- **Class 958 - Item 91:** Transit Management Services

Respondents are not required to use, nor limited to using, the class and item codes identified above, and may identify other areas for subcontracting. However, the NIGP class/item codes are preferred with all responses.

HHSC does not endorse, recommend nor attest to the capabilities of any company or individual listed on the CPA's CMBL. The list of certified HUBs is subject to change, so respondents are encouraged to refer to the CMBL often to find the most current listing of HUBs.

4.6 HUB Subcontracting Procedures – If a Respondent Intends to Subcontract

An HSP must demonstrate that the respondent made a good faith effort to comply with HHSC's HUB policies and procedures. The following subparts outline the items that HHSC will review in determining whether an HSP meets the good faith effort standard. A respondent that intends to subcontract must complete the HSP to document its good faith efforts.

4.6.1 Identify Subcontracting Areas and Divide Them into Reasonable Lots

A respondent should first identify each area of the contract work it intends to subcontract. Then, to maximize HUB participation, it should divide the contract work into reasonable lots or portions, to the extent consistent with prudent industry practices.

4.6.2 Notify Potential HUB Subcontractors

The HSP must demonstrate that the respondent made a good faith effort to subcontract with HUBs. The respondent's good faith efforts shall be shown through utilization of all methods in conformance with the development and submission of the HSP and by complying with the following steps:

4.6.2.1 Divide the contract work into reasonable lots or portions to the extent consistent with prudent industry practices. The respondent must determine which portions of work, including goods and services, will be subcontracted.

4.6.2.2 Use the appropriate method(s) to demonstrate good faith effort. The respondent can use either method(s) 1, 2, 3, or 4:

4.6.3 Method 1: Respondent Intends to Subcontract with only HUBs:

The respondent must identify in the HSP the HUBs that will be utilized and submit written documentation that confirms 100% of all available subcontracting opportunities will be performed by one or more HUBs; **or,**

4.6.4 Method 2: Respondent Intends to Subcontract with HUB Protégé(s):

The respondent must identify in the HSP the HUB protégé(s) that will be utilized and should:

- Include a fully executed copy of the Mentor Protégé Agreement, which must be registered with the CPA prior to submission to HHSC; and
- Identify areas of the HSP that will be performed by the protégé.

HHSC will accept a Mentor Protégé Agreement that has been entered into by a respondent (mentor) and a certified HUB (protégé) in accordance with Texas Government Code §2161.065. When a respondent proposes to subcontract with a protégé(s), it does not need to provide notice to three (3) HUB vendors for that subcontracted area.

Participation in the Mentor Protégé Program, along with the submission of a protégé as a subcontractor in an HSP, constitutes a good faith effort for the particular area subcontracted to the protégé; or,

4.6.5 Method 3: Respondent Intends to Subcontract with HUBs and Non-HUBs (Meet or Exceed the Goal):

The respondent must identify in the HSP and submit written documentation that one or more HUB subcontractors will be utilized; and that the aggregate expected percentage of subcontracts with HUBs will meet or exceed the goal specified in this solicitation. When utilizing this method, only HUB subcontractors that has existing contracts with the respondent for five years or less may be used to comply with the good faith effort requirements.

When the aggregate expected percentage of subcontracts with HUBs meets or exceeds the goal specified in this solicitation, respondents may also use non-HUB subcontractors; or,

4.6.6 Method 4: Respondent Intends to Subcontract with HUBs and Non-HUBs (Does Not Meet or Exceed the Goal):

The respondent must identify in the HSP and submit documentation regarding the following requirements:

- Written notification to minority or women trade organizations or development centers to assist in identifying potential HUBs of the subcontracting opportunities the respondent intends to subcontract.

  Respondents must give minority or women trade organizations or development centers at least seven (7) working days prior to submission of the respondent's response for dissemination of the subcontracting opportunities to their members. A list of minority and women trade organizations is located on HHSC's website under the Minority and Women Organization link.

- Written notification to at least three (3) HUB businesses of the subcontracting opportunities that the respondent intends to subcontract. The written notice must be sent to potential HUB subcontractors prior to submitting proposals and must include:

  - a description of the scope of work to be subcontracted;
  - information regarding the location to review project plans or specifications;
  - information about bonding and insurance requirements;
  - required qualifications and other contract requirements; and
  - a description of how the subcontractor can contact the respondent.

  Respondents must give potential HUB subcontractors a reasonable amount of time to respond to the notice, at least seven (7) working days prior to submission of the respondent's response unless circumstances require a different time period, which is determined by the agency and documented in the contract file;

Respondents must also use the CMBL, the HUB Directory, and Internet resources when searching for HUB subcontractors. Respondents may rely on the services of contractor groups; local, state and federal business assistance offices; and other organizations that provide assistance in identifying qualified applicants for the HUB program.

4.6.7 Written Justification of the Selection Process

HHSC will make a determination if a good faith effort was made by the respondent in the development of the required HSP. One or more of the methods identified in the previous sections may be applicable to the respondent's good faith efforts in developing and submission of the HSP. HHSC may require the respondent to submit additional documentation explaining how the respondent made a good faith effort in accordance with the solicitation.

A respondent must provide written justification of its selection process if it chooses a non-HUB subcontractor. The justification should demonstrate that the respondent negotiated in good faith with qualified HUB bidders, and did not reject qualified HUBs who were the best value responsive bidders.

4.7 Method 5: Respondent Does Not Intend to Subcontract

When the respondent plans to complete all contract requirements with its own equipment, supplies, materials and/or employees, it is still required to complete an HSP.

The respondent must complete the "Self Performance Justification" portion of the HSP, and attest that it does not intend to subcontract for any goods or services, including the class and item codes identified in Section 4.5. In addition, the respondent must identify the sections of the proposal that describe how it will complete the Scope of Work using its own resources or provide a statement explaining how it will complete the Scope of Work using its own resources. The respondent must agree to comply with the following if requested by HHSC:

- provide evidence of sufficient respondent staffing to meet the RFP requirements;
- provide monthly payroll records showing the respondent staff fully dedicated to the contract;
- allow HHSC to conduct an on-site review of company headquarters or work site where services are to be performed and,
- provide documentation proving employment of qualified personnel holding the necessary licenses and certificates required to perform the Scope of Work.

4.8 Post-award HSP Requirements

The HSP shall be reviewed and evaluated prior to contract award and, if accepted, the finalized HSP will become part of the contract with the successful respondent(s).

After contract award, HHSC will coordinate a post-award meeting with the successful respondent to discuss HSP reporting requirements. The contractor must maintain business records documenting compliance with the HSP, and must submit monthly subcontract reports to HHSC by completing the HUB "Prime Contractor Progress

Assessment Report." This monthly report is required as a condition for payment to report to the agency the identity and the amount paid to all subcontractors.

As a condition of award the Contractor is required to send notification to all selected subcontractors as identified in the accepted/approved HSP. In addition, a copy of the notification must be provided to the agency's Contract Manager and/or HUB Program Office within 10 days of the contract award.

During the term of the contract, if the parties in the contract amend the contract to include a change to the scope of work or add additional funding, HHSC will evaluate to determine the probability of additional subcontracting opportunities. When applicable, the Contractor must submit an HSP change request for HHSC review. The requirements for an HSP change request will be covered in the post-award meeting.

When making a change to an HSP, the Contractor will obtain prior written approval from HHSC before making any changes to the HSP. Proposed changes must comply with the HUB Program good faith effort requirements relating to the development and submission of a HSP.

If the contractor decides to subcontract any part of the contract after the award, it must follow the good faith effort procedures outlined in Section 4.6 of this RFP (e.g., divide work into reasonable lots, notify at least three (3) vendors per subcontracted area, provide written justification of the selection process, or participate in the Mentor Protégé Program).

For this reason, HHSC encourages respondents to identify, as part of their HSP, multiple subcontractors who are able to perform the work in each area the respondent plans to subcontract. Selecting additional subcontractors may help the selected contractor make changes to its original HSP, when needed, and will allow HHSC to approve any necessary changes expeditiously.

Failure to meet the HSP and post-award requirements will constitute a breach of contract, and will be subject to remedial actions. HHSC may also report noncompliance to the CPA in accordance with the provisions of the Vendor Performance and Debarment Program.

5. Proposal Evaluation

HHSC will use a formal evaluation process to select the successful respondent(s). HHSC will consider capabilities or advantages that are clearly described in the proposal, which may be confirmed by oral presentations, site visits, demonstrations, and references contacted by HHSC. HHSC reserves the right to contact individuals, entities, or organizations that have had dealings with the respondent or proposed staff, whether or not identified in the proposal.

HHSC will more favorably evaluate proposals that offer no or few exceptions, reservations, or limitations to the terms and conditions of the RFP, including HHSC's UTCs.

5.1 Evaluation Criteria

HHSC will evaluate proposals based on the following best value criteria, listed in order of precedence listed or developed from the best value factors listed in Section 1.16:

1. The extent to which the Respondent's proposal meets the needs of the clients for whom the nonemergency medical transportation services are being purchased, and the needs of HHSC:

    - The extent to which the Respondent's proposal addresses HHSC's priority objectives for the Initial Contract Period, as defined in the RFP;
    - The overall savings resulting from the contract, including a consideration of the amount of federal financial participation (FFP) available to HHSC under the resulting contract;
    - The degree to which the proposal demonstrates program innovation, adaptability, and exceptional customer service ; and
    - The extent to which the respondent accepts without reservation or exception the RFP's terms and conditions.

2. Indicators of probable Respondent performance under the Contract, including past performance in Texas or comparable experience, financial resources and ability to perform, and relevant Respondent organizational experience.

3. Effect of the potential acquisition on agency productivity; including the level of effort and resources required to monitor the Respondent's performance under the Contract and maintain a good working relationship with the Respondent.

4. Any other relevant factor as ordered in Texas Administrative Code, Title 1, Part 15, Chapter 391, Subchapter D, Rule §391.121.

5.2 Initial Compliance Screening

HHSC will perform an initial screening of all proposals received. Unsigned proposals and proposals that do not include all required forms and sections are subject to rejection without further evaluation.

In accordance with Section 3.3, HHSC reserves the right to waive minor informalities in a proposal and award contracts that are in the best interest of the State of Texas.

5.3 Competitive Field Determinations

HHSC may determine that certain proposals are within the field of competition for admission to discussions. The field of competition consists of the proposals that receive the highest or most satisfactory evaluations. HHSC may, in the interest of administrative efficiency, place reasonable limits on the number of proposals admitted to the field of competition.

5.4 Oral Presentations and Site Visits

HHSC may, at its sole discretion, request oral presentations, site visits, and/or demonstrations from one or more respondents admitted to the field of competition. HHSC will notify selected respondents of the time and location for these activities, and may supply agendas or topics for discussion. HHSC reserves the right to ask additional questions during oral presentations, site visits, and or demonstrations to clarify the scope and content of the written proposal.

The respondent's oral presentation, site visit, and/or demonstration must substantially represent material included in the written proposal, and should not introduce new concepts or offers unless specifically requested by HHSC.

5.5 Best and Final Offers

HHSC may, but is not required to, permit respondents to prepare one or more revised offers. For this reason, respondents are encouraged to treat their original proposals, and any revised offers requested by HHSC, as best and final offers.

5.6 Discussions with Respondents

HHSC may, but is not required to, conduct discussions with all, some, or none of the respondents admitted to the field of competition for the purpose of obtaining the best value for HHSC. It may conduct discussions for the purpose of:

- obtaining clarification of proposal ambiguities;
- requesting modifications to a proposal;
- determining best value; and/or,
- obtaining a best and final offer.

HHSC may make an award prior to the completion of discussions with all respondents admitted to the field of competition if HHSC determines that the award represents best value to the State of Texas.

6. Accounting and Financial Reporting Requirements

The MTO's accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with Federal Acquisition Regulations ("FAR"), Generally Accepted Accounting Principles (GAAP), and the cost principles contained in the Cost Principles Document in the Contract.

6.1 Accounting Reporting Requirements

The state will not recognize or pay services that cannot be properly substantiated by the MTO and verified by HHSC. The MTO must maintain the following records, information, systems, or documentation.

6.1.1 Corporate Accounting Records

Maintain accounting records for the HHSC Medical Transportation Program (MTP) separate and apart from other corporate accounting records.

6.1.2 Claims Records

Maintain records for all claims payments, refunds, and adjustment payments to Performing Providers, capitation payments, interest income, and payments for administrative services or functions, and must maintain separate records for administrative fees, charges, and payments.

6.1.3 Accounting System

Maintain an accounting system that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial statements with all general ledger accounts.

- The MTO agrees to pay for all reasonable cost incurred by HHSC or its designee to perform an examination, review, or audit of the MTO's books pertaining to the Contract.

- Allow authorized representatives of the Texas and federal governments full access to all financial and accounting records related to the performance of the Contract.

- Cooperate with the state and federal governments in their evaluation, inspection, audit, or review of accounting records and any necessary supporting information.

- Permit authorized representatives of the state and federal government full access, during normal business hours, to the accounting records that the state and the federal governments determine are relevant to the Contract. Access is guaranteed at all times during the performance and retention period of the Contract, and will include both announced and unannounced inspections, on-site audits, and the review, analysis, and reproduction of reports produced by the MTO.

- Make copies of any accounting records or supporting documentation relevant to the Contract, including Performing Provider agreements, available to HHSC or its agents within seven Business Days, or as otherwise specified by HHSC, of receiving a written request from HHSC for specified records or information.

6.1.4 Remedy

If the documentation is not made available as requested, the MTO agrees to:

- Reimburse HHSC for all costs, including, but not limited to: transportation, lodging, and subsistence for all state and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, and reproduction functions at the location(s) of the accounting records; and

- Pay any and all additional costs incurred by the state and federal governments that are the result of the MTO's failure to provide the requested accounting records or financial information within 10 business days of receiving a written request from the state or federal government

6.2 Financial Reporting Requirements

6.2.1 Reports

HHSC will require the MTO to provide financial reports by region to support contract monitoring as well as state and federal reporting requirements. HHSC will consult with MTOs regarding the format and frequency of the reporting. All financial information and reports are the property of HHSC and will be public record, with the exception of any protected member information contained within the documents. Any deliverable or report in this section without a specified due date is due quarterly on the last day of the month. Where the due date states 30 days, the MTO is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 days, the MTO is to provide the deliverable by the 15th day of the second month following the end of the reporting period. The Contract will govern the timing, format and content for the following reports.

6.2.1.1 Audited Financial Statement –The MTO must provide its annual *audited* financial statement for each MTO fiscal year included or partially included under the Contract, by no later than four (4) months of the close of that fiscal year.

6.2.1.2 Affiliate Report – The MTO must submit an Affiliate Report to HHSC. The instructions for the report are included in Attachment R, Affiliate Report.

6.2.1.3 Employee Bonus or Incentive Payment Plan – If an MTO intends to include Employee Bonus or Incentive Payments as allowable administrative expenses, the MTO must furnish a written Employee Bonus or Incentive Payments Plan to HHSC so it may determine whether the payments are allowable administrative expenses in accordance with the Cost Principles document in the Contract. The written plan must include a description of the MTO's criteria for establishing bonus or incentive payments, the methodology to calculate bonus or incentive payments, and the timing of bonus or incentive payments. The Bonus or Incentive Payment Plan and description must be submitted to HHSC for approval no later than 30 days after the Effective Date of the Contract and any Contract renewal. If the MTO substantively revises the Employee Bonus or Incentive Payment Plan, the MTO must submit the revised plan to HHSC for prior review and approval.

6.2.1.4 MTO Disclosure Statement - The MTO must file:

- an updated MTO Disclosure Statement, as defined by HHSC, by September 1st of each Contract Year; and
- a "change notification" abbreviated version of the report, no later than 30 days after any of the following events:
  - entering into, renewing, modifying, or terminating a relationship with an affiliated party;
  - a change in control, ownership, or affiliations; or

- a material change in, or need for addition to, the information previously disclosed.

The instructions for the MTO Disclosure Statement are included in Attachment M, MTO Disclosure Statement.

6.2.1.5 Financial Statistical Reports (FSR)

The MTO must file quarterly and annual Financial-Statistical Reports (FSR) in the format and timeframe specified by HHSC. The MTO must incorporate financial and statistical data of delegated networks, if any, in its FSR Reports. All expenses reported in the FSRs must be reported in accordance with the Cost Principles document in the Contract. Quarterly FSR reports are due no later than 30 days after the end of the quarter and must provide information for the current quarter and year-to-date information through the current quarter. The first annual FSR report must reflect expenses incurred through the 15th day after the end of the fiscal year. The first annual report must be filed on or before the 45th day after the end of each fiscal year. Subsequent annual reports must reflect data completed through the 90th day after the end of each fiscal year and must be filed on or before the 120th day following the end of each fiscal year. The final FSR is routinely audited by HHSC and/or its independent auditors. HHSC may post FSRs on the HHSC website. Instructions for the FSRs are included in Attachment L, MTP Financial Statistical Report.

6.2.1.6 Report of Legal and Other Proceedings and Related Events

The MTO must comply with the requirements specified in Attachment O regarding the disclosure of certain legal matters involving the MTO, its Affiliates, or its Material Subcontractors. A report should be submitted with the proposal and then subsequently, reports are due both on an as-occurs basis and annually each August 31st. The as-occurs report is due no later than thirty (30) days after the event that triggered the notification requirement.

6.2.1.7 Audit Reports

The MTO must provide HHSC with copies of any internal or external audit reports, including financial audits, attestation engagements, compliance examinations, financial or fiscal inspections, other financially related audits and related reviews, reports, studies, analysis and filings, and any related audit communications, including audit letters. This requirement excludes audits for billing and coding errors, reports on claims and enrollment. The MTO must provide electronic copies of the reports to HHSC MTP within forty-five (45) days of the issuance of the draft report.

6.3 Record Retention and Audit

MTO agrees to maintain, and require its Performing Providers and Material Subcontractors to maintain, records, books, documents, and information (collectively “records”) that are adequate to ensure that services are provided and payments are made in accordance with the requirements of the contract, including applicable Federal and State requirements (e.g., 45 CFR §74.53). Such records must be retained by MTO,

Performing Providers and Material Subcontractors for a period of five (5) years after the Contract Expiration Date or until the resolution of all litigation, claim, financial management review or audit pertaining to the contract, whichever is longer.

6.4 Access to Records, Books, and Documents

6.4.1 Reasonable Access

6.4.1.1 Upon reasonable notice, MTO must provide, and cause its Material Subcontractors and Performing Providers to provide, the officials and entities identified in this Section with prompt, reasonable, and adequate access to any records that are related to the scope of the contract.

6.4.1.2 MTO, Material Subcontractors and Performing Providers must provide the access described in this Section upon HHSC's request. This request may be for, but is not limited to, the following purposes:

- Examination;
- Audit;
- Investigation;
- Contract administration; or
- The making of copies, excerpts, or transcripts.

6.4.1.3 The access required must be provided to the following officials and/or entities:

- The United States Department of Health and Human Services or its designee;
- The Comptroller General of the United States or its designee;
- MTP personnel from HHSC or its designee;
- The Office of Inspector General;
- The Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;
- Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC;
- The Office of the State Auditor of Texas or its designee;
- A State or Federal law enforcement agency;
- A special or general investigating committee of the Texas Legislature or its designee; and
- Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

6.4.1.4 MTO agrees to provide the access described wherever MTO maintains such books, records, and supporting documentation. MTO further agrees to provide such access in reasonable

comfort and to provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described in this Section. MTO will require its Material Subcontractors and Performing Providers to provide comparable access and accommodations.

6.4.2 MTO Responsibilities

6.4.2.1 Upon request, the MTO must provide copies of the information described in this Section free of charge to HHSC and the entities described in subsection (c).

6.4.2.2 In accordance with Texas Government Code §533.012(e), any information submitted to HHSC or the Texas Attorney General's Office pursuant to Texas Government Code §533.012(a)(1) is confidential and is not subject to disclosure under the Texas Public Information Act.

6.5 Audits of Services, Deliverables and Inspections

6.5.1 MTO Responsibilities

6.5.1.1 Upon reasonable notice from HHSC, MTO will provide, and will cause its Material Subcontractors and Performing Providers to provide, such auditors and inspectors as HHSC may from time to time designate, with access to:

- service locations, facilities, or installations;
- records; and
- Software and Equipment.

6.5.1.2 The access described in this Section will be for the purpose of examining, auditing, or investigating:

- MTO's capacity to bear the risk of potential financial losses;
- Services and Deliverables provided;
- Determination of the amounts payable under the contract;
- Determination of the allowability of costs reported under the contract;
- Examination of Subcontract terms and/or transactions;
- Assessment of financial results under the contract;
- Detection of Fraud, Waste and/or Abuse; or
- Other purposes HHSC deems necessary to perform its oversight function and/or enforce the provisions of the contract.

6.5.1.3 MTO must provide, as part of the Scope of Work, any assistance that such auditors and inspectors reasonably may require to complete such audits or inspections.

6.5.1.4 If, as a result of an audit or review of payments made to the MTO, HHSC discovers a payment error or overcharge, HHSC will notify the MTO of such error or overcharge. HHSC will be entitled to recover such funds as an offset to future payments to the MTO, or to collect such funds directly from the MTO. MTO must return funds owed to HHSC within 30 days after receiving notice of the error or overcharge, or interest will accrue on the amount due. HHSC will calculate interest at 12% per annum, compounded daily. The return of funds within 30 days does not exempt the MTO from any interest that may be due with respect to the calculation of interest under the Experience Rebate; see Section 6.12. In the event that an audit reveals that errors in reporting by the MTO have resulted in errors in payments to the MTO or errors in the calculation of the Experience Rebate, the MTO will indemnify HHSC for any losses resulting from such errors, including the cost of audit. If the interest rate stipulated hereunder is found by a court of competent jurisdiction to be outside the range deemed legal and enforceable, then the rate hereunder will be adjusted as little as possible so as to be deemed legal and enforceable.

6.6 SAO Audit

The MTO understands that acceptance of funds under the contract acts as acceptance of the authority of the State Auditor's Office (SAO), or any successor agency, to conduct an investigation in connection with those funds. The MTO further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested. The MTO will ensure that this clause concerning the authority to audit funds and the requirement to cooperate is included in any Material Subcontract.

6.7 Response/Compliance with Audit or Inspection Findings

6.7.1 MTO Responsibilities

6.7.1.1 MTO must take action to ensure its Material Subcontractors or a Performing Provider's compliance with or correction of any finding of noncompliance with any law, regulation, audit requirement, or generally accepted accounting principle relating to the Services and Deliverables or any other deficiency contained in any audit, review, or inspection conducted under this Article. This action will include MTO's delivery to HHSC, for HHSC'S approval, a Corrective Action Plan that addresses deficiencies identified in any audit, review, or inspection within 30 calendar days of the close of the audit, review, or inspection.

6.7.1.2 MTO must bear the expense of compliance with any finding of noncompliance under this Section that is:

- Required by Texas or Federal law, regulation, rule, court order, or other audit requirement relating to MTO's business;
- Performed by MTO as part of the Scope of Work; or
- Necessary due to MTO's noncompliance with any law, regulation, rule, court order, or audit requirement imposed on MTO.

As part of the Scope of Work, MTO must provide to HHSC upon request a copy of those portions of MTO's, Material Subcontractors' and Performing Providers' internal audit reports relating to the Services and Deliverables provided to HHSC under the Contract.

6.8 Notification of Legal and Other Proceedings, and Related Events

The MTO must notify HHSC of all proceedings, reports, documents, actions, and events.

6.9 Capitation Payments

This is a Risk-based contract which means that the MTO is at-risk for expenses that may be necessary or incurred in order to deliver contractually required services and deliverables, even if such expenses are in excess of the Capitation Payments received.

6.9.1 Applicable rules

6.9.1.1 HHSC will pay the MTO fixed monthly Capitation Payments based on the number of eligible enrolled clients. HHSC will calculate the monthly Capitation Payments by multiplying the number of clients in each Rate Cell by the Capitation Rate for each Rate Cell. In consideration of the monthly Capitation Payments, the MTO agrees to provide the Services and Deliverables described in the contract.

6.9.1.2 MTO will be required to provide timely financial and statistical information necessary in the Capitation Rate determination process. Encounter Data provided by MTO must conform to all HHSC requirements. Encounter Data containing non-compliant information, including, but not limited to, inaccurate client identification numbers, inaccurate provider identification numbers, or service codes insufficient to adequately describe the specific type of transportation services provided, may not, at HHSC's discretion, be considered in the MTO's experience for rate-setting purposes. This could result in the derivation of a lower Capitation Rate.

6.9.1.3 Information or data, including complete and accurate Encounter Data, as requested by HHSC for rate-setting purposes, must be provided to HHSC: within thirty (30) days of receipt of the letter from HHSC requesting the information or data.

6.9.1.4 The fixed monthly Capitation Rate consists of the following components:

- an amount for Transportation Services (including meals, lodging, and advanced funds) provided during the month;
- an amount for administering the MTP Program (including all deliverables required), and
- an amount for the MTO's Risk margin.

Capitation Rates for the MTOs may vary by region.

6.9.1.5 MTO understands and expressly assumes the risks associated with the performance of the duties and responsibilities under the Contract, including the failure, termination or suspension of funding to HHSC, delays or denials of required approvals, and cost overruns not reasonably attributable to HHSC.

6.10 Time and Manner of Payment

6.10.1 Payment

6.10.1.1 During the Contract Term and beginning after the Operational Start Date, HHSC will pay the monthly Capitation Payments by the 10th Business Day of each month.

6.10.1.2 The MTO must accept Capitation Payments by direct deposit into the MTO's account.

6.10.1.3 HHSC may adjust the monthly Capitation Payment to the MTO in the case of an overpayment to the MTO; for Experience Rebate amounts due and unpaid, including any associated interest; for Liquidated Damages due and unpaid, including any associated interest; and if any other monetary damages are assessed.

6.10.1.4 HHSC's payment of monthly Capitation Payments is subject to availability of federal and state appropriations. If appropriations are not available to pay the full monthly Capitation Payment, HHSC may:

- Equitably adjust Capitation Payments for all participating MTOs, and reduce scope of service requirements as appropriate, or
- Terminate the Contract.

6.10.2 Modification of Capitation Rates

The Parties expressly understand and agree that the agreed Capitation Rates are subject to modification, if changes in state or federal laws, rules, regulations, guidelines, policies, or court orders affect the rates. HHSC will provide the MTO notice of a modification to the Capitation Rates at least 60 days prior to the effective date of the change, unless HHSC determines that circumstances warrant a shorter notice period. If the MTO does not accept the rate change, either Party may terminate the Contract.

6.11 Medical Transportation Program Capitation Structure

6.11.1 Rate Periods

6.11.1.1 A Rate Period is usually the State Fiscal Year (SFY). A State Fiscal Year is the twelve-month period that commences on September 1st and ends on August 31st. If the Operational Start Date of this Agreement does not commence on the first day of an SFY, then the first Rate Period may be the remaining portion of the then-current SFY.

6.11.2 MTO Rate Cells

6.11.2.1 MTO Capitation Rates are defined on a per Member per month basis by Rate Cells and Service Areas. MTO Rate Cells are:

- Urban Under Age 21(Medicaid);
- Rural Under Age 21(Medicaid);
- Urban Age 21 and Over (Medicaid);
- Rural Age 21 and Over (Medicaid);
- Children with Special Healthcare Needs or Indigent Cancer Patients (non-Medicaid; all ages);

These Rate Cells are subject to change.

6.11.3 MTO Capitation Rate development

HHSC will establish base Capitation Rates by analyzing claims data for the Medicaid Transportation Program and Service Area. This analysis will include a review of historical enrollment and claims experience information; financial data; any changes to covered health care services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information. Value-added services will not be included in the rate-setting process.

6.11.4 MTO input during rate setting process

6.11.4.1 MTOs must provide Encounter Data as described in Section 2.28.1 and financial data as set forth in the FSR. Such information may include, without limitation: monthly claims lag information by Rate Cell and administrative expenses. HHSC may request clarification or additional financial information from the MTO. HHSC will notify the MTO of the deadline for submitting a response, which will include a reasonable amount of time for response.

6.11.4.2 HHSC will allow the MTO to review and comment on certain data elements used by HHSC to determine base Capitation Rates. HHSC will notify the MTO of the deadline for submitting comments, which will include a reasonable amount of time for

response. HHSC will not consider comments received after the deadline in its rate analysis.

6.11.4.3 During the rate setting process, HHSC will conduct at least one meeting with the MTOs. HHSC may conduct the meeting in person, via teleconference, or by another method deemed appropriate by HHSC. Prior to the meeting, HHSC will provide the MTO with proposed Capitation Rates. During the meeting, HHSC will describe the process used to generate the proposed Capitation Rates, discuss major changes in the rate setting process, and receive input from MTOs. HHSC will notify MTOs of the deadline for submitting comments, which will include a reasonable amount of time to review and comment on the proposed Capitation Rates and rate setting process.

6.11.5 Adjustments to Capitation Payments

6.11.5.1 Monthly adjustments. In most months after the first month, HHSC will add to, and/or subtract from, the standard capitation payment, in order to reflect adjustments for the prior month(s) for clients that were added to, or removed from, the MTO region's enrollment after the Enrollment File cut-off date.

6.11.5.2 Recoupment. HHSC may recoup a payment made to the MTO for a client if:

- the client is enrolled into the MTO in error;
- the client moves outside the United States;
- the client dies before the first day of the month for which the payment was made; or
- a client's eligibility status or program type is changed, corrected as a result of error, or is retroactively adjusted; or

6.11.5.3 Appeal of recoupment The MTO may appeal the recoupment or adjustment of capitations in the above circumstances using the HHSC dispute resolution process

6.12 Experience Rebate

6.12.1 MTO's Duty to Pay

6.12.1.1 At the end of each FSR Reporting Period beginning with the first FSR Reporting Period hereunder, FSR Reporting Period 15, the MTO must pay an Experience Rebate if the MTO's Net Income Before Taxes is greater than the percentage set forth below of the total Revenue for the period. The Experience Rebate is calculated in accordance with the tiered rebate method set forth below. The Net Income Before Taxes and the total Revenues are as measured by the FSR, as reviewed and confirmed by HHSC. The final amount used in the calculation of the percentage may be impacted by various factors herein,

including the Loss Carry Forward, the Admin Cap, and/or the Reinsurance Cap.

6.12.1.2 Basis of Consolidation. The percentages are calculated on a Consolidated Basis, and include the consolidated Net Income Before Taxes for all of the MTO's and its Affiliates' Texas HHSC Programs and Regions (including any Service Delivery Areas).

6.12.2 Graduated Experience Rebate Sharing Method

Pre-tax Income as a % of Revenues	MTO Share	HHSC Share
≤ 5%	100%	0%
> 5% and ≤ 8%	60%	40%
> 8% and ≤ 12%	35%	65%
> 12%	15%	85%

6.12.2.1 HHSC and the MTO will share the consolidated Net Income Before Taxes for its HHSC Programs as follows:

6.12.2.1.1 The MTO will retain all the Net Income Before Taxes that is equal to or less than 5% of the total Revenues received by the MTO;

6.12.2.1.2 HHSC and the MTO will share that portion of the Net Income Before Taxes that is over 5% and less than or equal to 8% of the total Revenues received, with 60% to the MTO and 40% to HHSC.

6.12.2.1.3 HHSC and the MTO will share that portion of the Net Income Before Taxes that is over 8% and less than or equal to 12% of the total Revenues received, with 35% to the MTO and 65% to HHSC.

6.12.2.1.4 HHSC and the MTO will share that portion of the Net Income Before Taxes that exceeds 12% of the total Revenues received, with 15% to the MTO and 85% to HHSC.

6.12.3 Net Income Before Taxes

6.12.3.1 The MTO must compute the Net Income Before Taxes in accordance with applicable federal regulations and the "Cost Principles for Expenses," which is included in Attachment K, Cost Principles for Expenses, "MTP FSR Instructions for Completion," and similar such HHSC instructions. The Net Income Before Taxes will be confirmed by HHSC or its agent for the FSR Reporting Period relating to all Revenues and Allowable Expenses incurred pursuant to the Contract. HHSC

reserves the right to modify the “Cost Principles for Expenses” and “FSR Instructions for Completion”

6.12.3.2 For purposes of calculating Net Income Before Taxes, certain items are omitted from the calculation, as they are not Allowable Expenses; these include, but are not limited to:

- The payment of an Experience Rebate or Liquidated Damage assessment;
- Any interest expense associated with late or underpayment of the Experience Rebate or Liquidated Damage assessment;
- Any HHSC financial incentives or financial disincentives, as may be applicable. See “Cost Principles for Expenses in Attachment K.”

6.12.4 Carry forward of prior FSR Reporting Period losses

6.12.4.1 General Losses incurred on a Consolidated Basis for a given FSR Reporting Period may be carried forward to the next FSR Reporting Period, and applied as an offset against consolidated pre-tax net income for determination of any Experience Rebate due. Any such prior losses may be carried forward for the next two (2) contiguous FSR Reporting Periods.

6.12.4.2 In the case when a loss in a given FSR Reporting Period is carried forward and applied against profits in either or both of the next two (2) FSR Reporting Periods, the loss must first be applied against the first subsequent FSR Reporting Period such that the profit in the first subsequent FSR Reporting Period is reduced to a zero pre-tax income; any additional loss then remaining unapplied may be carried forward to any profit in the next subsequent FSR Reporting Period. In such case, the revised income in the third FSR Reporting Period would be equal to the cumulative income of the three (3) contiguous FSR Reporting Periods. In no case could the loss be carried forward to the fourth FSR Reporting Period or beyond. Carrying forward of losses may be impacted by the Admin Cap. Losses incurred in the last or next-to-last FSR Reporting Period of a prior contiguous contract with HHSC may be carried forward up to two (2) FSR Reporting Periods into the first or potentially second FSR Reporting Period of the Contract, if such losses meet all other requirements of both the prior and current contracts.

6.12.4.3 Basis of consolidation. In order for a loss to be eligible for potential carry forward as an offset against future income, the MTO must have a negative Net Income Before Taxes for an FSR Reporting Period on a Consolidated Basis**.**

6.12.5 Settlements for payment

6.12.5.1 There may be one (1) or more MTO payment(s) of the State share of the Experience Rebate on income generated for a given Financial Reporting Period. The first scheduled payment (the "Primary Settlement") will equal 100% of the State share of the Experience Rebate as derived from the FSR, and will be paid on the same day the Q4 FSR Report is submitted to HHSC.

6.12.5.2 The "Primary Settlement," as utilized herein, refers strictly to what should be paid with the Q4 FSR, and does not refer to the first instance in which an MTO may tender a payment. For example, an MTO may submit a Q4 FSR indicating no Experience Rebate is due, but then submit a 120-day FSR with a higher income and a corresponding Experience Rebate payment. In such case, this initial payment would be subsequent to the Primary Settlement.

6.12.5.3 The next scheduled payment will be an adjustment to the Primary Settlement, if required, and will be paid on the same day that the 120-day FSR Report is submitted to HHSC if the adjustment is a payment from the MTO to HHSC. An MTO may make non-scheduled payments at any time to reduce the accumulation of interest. For any nonscheduled payments prior to the 120-day FSR, the MTO is not required to submit a revised FSR, but is required to submit an Experience Rebate calculation form and an adjusted summary page of the FSR. The FSR summary page is labeled "Page 4: Summary Income Statement."

6.12.5.4 HHSC or its agent routinely audit or review the FSRs. If HHSC determines that corrections to the FSRs are required, based on an HHSC audit/review or other documentation acceptable to HHSC, then HHSC will make final adjustments. Any payment resulting from an audit or final adjustment will be due from the MTO within 30 days of the earlier of:

- The date of the management representation letter resulting from the audit; or
- The date of any invoice issued by HHSC.
- Payment within this 30-day timeframe will not relieve the MTO of any interest payment obligation that may exist.

6.12.5.5 In the event that any Experience Rebates and/or corresponding interest payments owed to the State are not paid by the required due dates, then HHSC may offset such amounts from any future Capitation Payments, or collect such sums directly from the MTO. HHSC may adjust the Experience Rebate if HHSC determines the MTO has paid amounts for goods or services that are not reasonable, necessary, or allowable in accordance with "Cost Principles for Expenses," "MTP FSR Instructions for

Completion," and the Federal Acquisition Regulations (FAR), or other applicable federal or state regulations. HHSC has final authority in auditing and determining the amount of the Experience Rebate

6.12.6 Interest on Experience Rebate

6.12.6.1 Interest on any Experience Rebate owed to HHSC will be charged beginning 35 days after the due date of the Primary Settlement, as described in Section 6.11.5.1. Thus, any Experience Rebate due or paid on or after the Primary Settlement will accrue interest starting at 35 days after the due date for the 45-day FSR Report. For example, any Experience Rebate payment (s) made in conjunction with the 120-day FSR, or as a result of audit findings, will accrue interest back to 35 days after the due-date for submission of the Q4 FSR.

6.12.6.2 If an audit or adjustment determines a downward revision of income after an interest payment has previously been required for the same State Fiscal Year, then HHSC will recalculate the interest and, if necessary, issue a full or partial refund or credit to the MTO.

6.12.6.3 Any interest obligations that are incurred pursuant to Section 6.12 that are not timely paid will be subject to accumulation of interest as well, at the same rate as applicable to the underlying Experience Rebate.

6.12.6.4 All interest assessed pursuant to Section 6.12 will continue to accrue until such point as a payment is received by HHSC, at which point interest on the amount received will stop accruing. If a balance remains at that point that is subject to interest, then the balance will continue to accrue interest. If interim payments are made, then any interest that may be due will only be charged on amounts for the time period during which they remained unpaid. By way of example only, if $100,000 is subject to interest commencing on a given day, and a payment is received for $75,000 forty-five (45) days after the start of interest, then the $75,000 will be subject to forty-five (45) days of interest, and the $25,000 balance will continue to accrue interest until paid. The accrual of interest as defined under Section 6.12.6 will not stop during any period of dispute. If a dispute is resolved in the MTO's favor, then interest will only be assessed on the revised unpaid amount

6.12.6.5 If the MTO incurs an interest obligation pursuant to Section 6.12 for an Experience Rebate payment, HHSC will assess such interest at 12% per annum, compounded daily. If any interest rate stipulated hereunder is found by a court of competent jurisdiction to be outside the range deemed legal and

enforceable, then the rate hereunder will be adjusted as little as possible so as to be deemed legal and enforceable.

6.12.6.6 Any such interest expense incurred pursuant to Section 6.12 is not an Allowable Expense for reporting purposes on the FSR.

6.12.7 Administrative Expense Cap

6.12.7.1 General requirement. The calculation methodology of Experience Rebates described in Section 6.12 will be adjusted by an Administrative Expense Cap ("Admin Cap"), commencing with FSR Reporting Period 16. (Note that the first FSR Reporting Period hereunder, FSR Reporting Period 15, will be exempt from the Admin Cap requirement.) The Admin Cap is a calculated maximum amount of administrative expense dollars (corresponding to a given FSR) that can be deducted from Revenues for purposes of determining income subject to the Experience Rebate. While administrative expenses may be limited by the Admin Cap to determine Experience Rebates, all valid Allowable Expenses will continue to be reported on the Financial Statistical Reports (FSRs). Thus, the Admin Cap does not impact FSR reporting, but may impact any associated Experience Rebate calculation. The calculation of any corresponding Experience Rebate due will be subject to limitations on total deductible administrative expenses.

6.12.7.2 Calculation Methodology. HHSC will determine the administrative expense component of the applicable Capitation Rate structure for each Program prior to each applicable Rate Period. At the conclusion of an FSR Reporting Period, HHSC will apply that predetermined administrative expense component against the MTO's actually incurred number of Member Months and aggregate premiums received (monthly Capitation Payments, which excludes any investment income or interest earned), to determine the specific Admin Cap, in aggregate dollars, for a given MTO. If rates are changed during the FSR Reporting Period, HHSC will use this same methodology of multiplying the predetermined HHSC rates for a given month against the ultimate actual number of member months or Revenues that occurred during that month, such that HHSC will apply each month's actual results against the rates that were in effect for that month.

6.12.7.3 Data sources. In determining the amount of Experience Rebate payment to include in the Primary Settlement (or in conjunction with any subsequent payment or settlement), the MTO will need to make the appropriate calculation, in order to assess the impact, if any, of the Admin Cap.

6.12.7.3.1 The total premiums paid by HHSC (received by the MTO), and corresponding Member Months, will be taken from the relevant FSR (or audit report) for the FSR Reporting Period.

6.12.7.3.2 There are two (2) components of the administrative expense portion of the Capitation Rate structure:

- The percentage rate to apply against the total premiums paid (the "percentage of premium" within the administrative expenses), and,

- The dollar rate per Member Month (the "fixed amount" within the administrative expenses). These will be taken from the supporting details associated with the official notification of final Capitation Rates, as supplied by HHSC. This notification is sent to the MTOs during the annual rate setting process via email, labeled as "the final rate exhibits for your plan." The email has one (1) or more spreadsheet files attached, which are particular to the given MTO. The spreadsheet(s) show the fixed amount and percentage of premium components for the administrative component of the Capitation Rate. The components of the administrative expense portion of the Capitation Rate can also be found on HHSC's Medicaid website, under "Rate Analysis for Managed Care Services." Under each Program, there is a separate Rate Setting document for each Rate Period that describes the development of the Capitation Rates. Within each such document, there is a section entitled "Administrative Fees," where it refers to "the amount allocated for administrative expenses."

- In any cases where the administrative expense portion of the Capitation Rate may refer to "the greater of (a) [one (1) set of factors], and (b) [another set of factors]," then the Admin Cap will be calculated each way, and the larger of the two (2) results will be the Admin Cap utilized for the determination of any Experience Rebates due.

6.12.7.4 Example of calculation

6.12.7.4.1 By way of example only, HHSC will calculate the Admin Cap for an FSR Reporting Period as follows:

(1) Multiply the predetermined administrative expense rate structure "fixed amount," or dollar rate per Member Month (for example, $0.22), by the actual number of Member Months for the Program during the FSR Reporting Period (for example, if the Region had an average of 200,000 enrolled Members, and it was a twelve-month period, there might be about 2,400,000 Member Months for the year):
$0.22 x 2,400,000 = $528,000.

(2) Multiply the predetermined percent of premiums in the administrative expense rate structure (for example, 19%), by the actual aggregate premiums earned for the Program during the FSR Reporting Period (for example, $6,000,000): 19.0% x $6,000,000 = $1,140,000.

(3) Add the totals of items 1 and 2, plus applicable premium taxes and maintenance taxes, if any (for example, $100,000), to determine the Admin Cap for the Program ($528,000 + $1,140,000) + $100,000 = $1,768,000.

In this example, $1,768,000 would be the Admin Cap for a single Region for an MTO in a particular FSR Reporting Period. Any administrative expenses reported in the FSR in excess of the amount calculated according to the method above would be adjusted out of the cost structure in the Experience Rebate calculation. Note that the actual numbers for premium dollars and for Member Months would be used, and thus they would not be "round numbers" as in the example above. Thus, the calculation would differ for each Region and for each year. Also note that the example admin rates of $0.22 PMPM and 19% of premiums are fictitious, and may be substantially different than the ultimately-determined real rates. The real rates will be posted when the capitation rates are set.

6.12.7.5 Consolidation and offsets

The Admin Cap will be first calculated individually by Program, and then totaled and applied on a Consolidated Basis. There will be one aggregate amount of dollars determined as the Admin Cap for each contracting managed care entity (MTO or MCO), which will cover all of an entity's and its Affiliates' Programs and Regions (including any Service Delivery Areas). This consolidated Admin Cap will be applied to the administrative expenses of the entity on a Consolidated Basis. The net impact of the Admin Cap will be applied to the Experience Rebate calculation. An Admin Cap calculation template will be provided at a later date.

6.12.7.6 Impact on Loss carry-forward

For Experience Rebate calculation purposes, the calculation of any loss carry-forward will be based on the allowable pre-tax loss as determined under the Admin Cap.

6.12.7.7 Contractors entering a Region or Program

If an MTO enters a new Region or offers a Program that it did not offer under a previous contract, it may be exempt from the Admin Cap for those Regions and Programs for a period of time to be determined by HHSC, up through the first FSR Reporting Period or portion thereof.

6.12.7.8 Unforeseen events

If, in HHSC's sole discretion, it determines that unforeseen events have created significant hardships for one (1) or more MTOs, HHSC may revise or temporarily suspend the Admin Cap as it deems necessary

6.13 Restriction on Assignment of Fees

During the term of the Contract, MTO may not, directly or indirectly, assign to any third party any beneficial or legal interest of the MTO in or to any payments to be made by HHSC pursuant to the Contract. This restriction does not apply to fees the MTO pays to Performing Providers for the performance of the Scope of Work.

6.14 Liability for Taxes

HHSC is not responsible in any way for the payment of any Federal, state or local taxes related to or incurred in connection with the MTO's performance of the Contract. MTO 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 any personal property taxes or income taxes levied on MTO or any taxes levied on employee wages.

6.15 Liability for Employment-Related Charges and Benefits

MTO will perform work under the Contract as an independent contractor and not as agent or representative of HHSC. MTO is solely and exclusively liable for payment of all employment-related charges incurred in connection with the performance of the Contract, including but not limited to salaries, benefits, employment taxes, workers compensation benefits, unemployment insurance and benefits, and other insurance or fringe benefits for Staff.

6.16 No Additional Consideration

6.16.1 Considerations

6.16.1.1 MTO will not be entitled to nor receive from HHSC any additional consideration, compensation, salary, wages, charges, fees, costs, or any other type of remuneration for Services and Deliverables provided under the Contract, except by properly authorized and executed Contract amendments.

6.16.1.2 No other charges for tasks, functions, or activities that are incidental or ancillary to the delivery of the Services and Deliverables will be sought from HHSC or any other state

agency, nor will the failure of HHSC or any other party to pay for such incidental or ancillary services entitle the MTO to withhold Services and Deliverables due under the Contract.

6.16.1.3 MTO will not be entitled by virtue of the Contract 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.

6.17 Federal Disallowance

If the federal government recoups money from the state for expenses and/or costs that are deemed unallowable by the federal government, the state has the right to, in turn, recoup payments made to the MTOs for these same expenses and/or costs, even if they had not been previously disallowed by the state and were incurred by the MTO, and any such expenses and/or costs would then be deemed unallowable by the state. If the state retroactively recoups money from the MTOs due to a federal disallowance, the state will recoup the entire amount paid to the MTO for the federally disallowed expenses and/or costs, not just the federal portion.

6.18 Audits

6.18.1 Annual Audited Financial Statements

Even if not required in the RFP and/or UTC Version 1.4.1, MTO will provide to HHSC, at no additional cost to HHSC, annual audited financial statements for MTO. These audited financial statements are to be of the actual legal entity that contracts with HHSC; substituting a parental financial statement is not acceptable to meet this requirement.

In addition to, and separate from, MTO's audited financials, if MTO is owned by a corporation, then MTO must also provide to HHSC annual audited financial statements for MTO's ultimate owner (parent company). This set of statements should be on a consolidated basis, which would include MTO and all subsidiaries owned by the parent company.

MTO must furnish to HHSC, during the Readiness Review process, the dates that mark the end of the fiscal year(s) for MTO, and for MTO's ultimate owner. Receipt of the audited financial statements by HHSC is due by four (4) months after the end of each entity's fiscal year. For fiscal years that coincide with the calendar year, these statements are due to HHSC by May 1st of each year, starting with May 1st, 2016. If MTO needs to pre-arrange a slightly different due date, it must obtain HHSC's permission in writing, at least thirty days prior to the four (4) month due date.

In addition to the standard income statement, balance sheet, statement of cash flows, etc., these audited financial statements must include the independent auditor's report (audit opinion letter to the Board or shareholders), the Notes to the financial statements, any written description(s) of legal issues or contingencies, any management discussion or analysis, and the name and address of the firm that performs the audit.

6.18.2 Periodic Audits

MTO is subject to periodic audits and reviews by federal and state oversight entities who, during the course of those audits and reviews, will evaluate MTO compliance with the provisions of the Agreement or services MTO provides under the Agreement.

All areas of responsibility and all Contract requirements will be subject to performance evaluation by HHSC. Performance reviews may be conducted at the discretion of HHSC at any time and may relate to any responsibility and/or requirement. MTO and its Performing Providers will comply with all requests by the auditors or reviewers for: (a) financial, performance, and other contract related information; and (b) access to staff, relevant to the objectives and scope of the audits or reviews.

During these audits or reviews, federal or state entities may select and test contract related transactions, and may select statistically valid samples of transactions selected from the population of all transactions of a certain type or within a certain period of time. The auditors or reviewers will examine the sampled transactions, and may apply the results of any disallowed costs they identify during their examination, using statistical extrapolation of the sample results to the entire population from which the sample was selected.

If auditors or reviewers identify costs during their review of contract compliance and MTO and/or MTO's Performing Providers' performance, that do not comply with the appropriate categories defined in the MTO Cost Principles or in the data reported in the FSRs, corrections may be applied that result in changes in rates or Experience Rebate amounts due to HHSC.

These audit and review provisions are not applicable to Liquidated Damages associated with the failure of MTO to meet its Performance Standards. Liquidated Damages will be based solely on individually identified instances of noncompliance or failure to meet performance measures, and are not subject to extrapolated results.

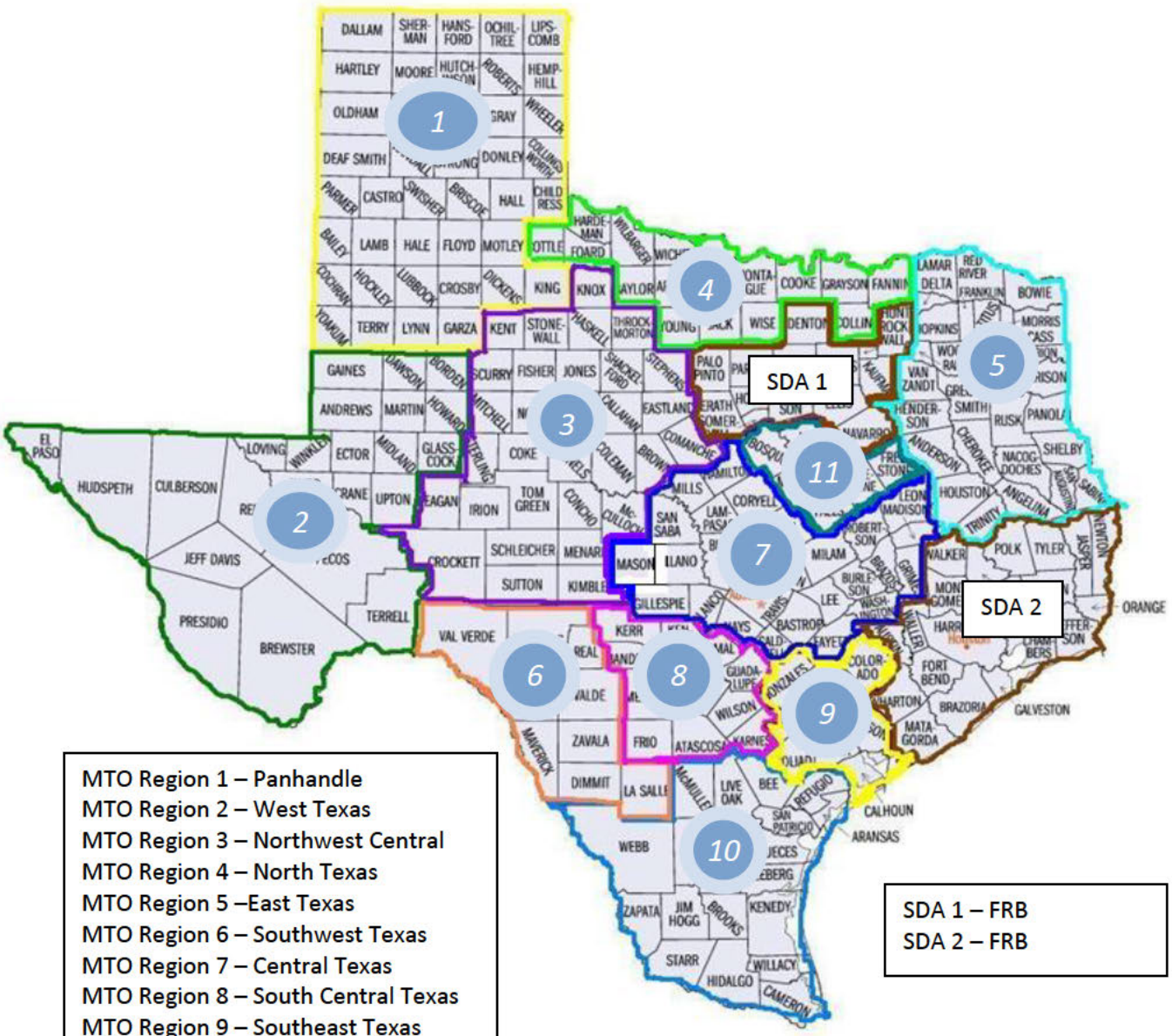
MTO will provide additional information to the degree of detail necessary to resolve any review, examination, inquiry, or audit by HHSC or any other state or federal authority upon request.

Attachment A – MTO Regions

Texas Health and Human Services Commission

Medical Transportation Program

MANAGED TRANSPORTATION ORGANIZATION (MTO) REGIONS
OPTION 3



MTO Region 1 – Panhandle
MTO Region 2 – West Texas
MTO Region 3 – Northwest Central
MTO Region 4 – North Texas
MTO Region 5 –East Texas
MTO Region 6 – Southwest Texas
MTO Region 7 – Central Texas
MTO Region 8 – South Central Texas
MTO Region 9 – Southeast Texas
MTO Region 10 – South Texas
MTO Region 11 – Northeast Central

SDA 1 – FRB
SDA 2 – FRB

Attachment B – Definitions and Acronyms

DEFINITIONS

Abuse	Practices that are inconsistent with sound fiscal, business, or transportation practices, and result in an unnecessary cost to the Medical Transportation Program (MTP), or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for NEMT services, or do not meet standards required by contract, statute, or regulation. It also includes beneficiary practices that result in unnecessary cost to MTP.
Accident	An unexpected and unfortunate medically important bodily event causing loss or injury to person. Accidents may involve loss of property (e.g., automobile)
Add-on (Additional) trips	A trip not authorized before the date of travel but provided to the client. Add-on trips are allowed under the following circumstances: • The services are prescribed by the client's healthcare provider. • The add-on trip (e.g., trip to a pharmacy, medical laboratory, or medical radiology facility) immediately follows an authorized healthcare appointment. • The add-on is an unexpected necessary attendant following all Medicaid rules and policies
Adjacent Counties	The county or counties that share a common county line or point with the client's county of residence.
Administrative Services or MTO Administrative Services	Performance by the MTO or its subcontractors of services or functions, other than the direct delivery of Covered Benefits, necessary for the management of the delivery of, and payment for, Covered Benefits, including Network, utilization, and/or quality management, service authorization, claims processing, management information systems operation, and reporting. Administrative Services also refers to the infrastructure for, preparation of, and delivery of, all required Deliverables under the Contract, outside of the Covered Benefits.
Advanced Funds	Funds authorized by the MTO in advance of travel and provided to the client or attendant to cover authorized transportation services, i.e. gas money for travel to a medically necessary health care service, lodging and/or meals in connection with a medically necessary health care service.
Affiliate	Any individual or entity who: • owns or holds more than a five percent (5%) interest in the MTO (either, directly, indirectly, or through one (1) one more

intermediaries);

- in which the MTO owns or holds more than a five percent (5%) interest (either, directly, indirectly, or through one (1) one more intermediaries)
- is a parent entity or subsidiary entity of the MTO, regardless of the organizational structure of the entity;
- is an entity that has a common parent with the MTO (either directly, indirectly, or through one (1) or more intermediaries);
- is the owner of a whole or part interest in any mortgage, deed of trust, note or other obligation secured (in whole or in part) by the entity that interest is equal to or exceeds 5% of the value of the property or assets of the MTO;
- is an entity that directly or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control, with the MTO;
- is an entity that would be considered to be an affiliate by and Securities and Exchange Commission (SEC) or Internal Revenue Service (IRS) regulation, Federal Acquisition Regulations (FAR), or by another applicable regulatory body.

Allowable Expenses

All expenses related to the Contract between HHSC and the MTO that are incurred during the Contract Period, are not reimbursable or recovered from another source, and that conform with HHSC's Cost Principles for Expenses as included in the contract.

Alternative Transportation Service (ATS)

Transportation service that is used when the transportation provider does not have available vehicle that meets the client's transportation needs. Alternative transportation service may include but is not limited to taxicab services.

Appeals

The administrative process through which the beneficiaries or providers can request a second level review by the Medical Transportation Program regarding adverse decisions in respect to eligibility, coverage, denial of service or payment taken by the MTO.

Attendant

An adult required to accompany a prior authorized MTP client under §380.207(4) (relating to Program Limitations) or an adult or service animal that accompanies a prior authorized MTP client to provide necessary mobility , personal or language assistance to the client during the time that transportation and health care services are provided.

Atypical Provider Identifier (API)

A ten (10) digit unique alphanumeric number assigned to MTP providers. It is an alternate method of tracking providers to NPI.

Broker

Transportation vendor responsible for establishing a network of providers, operating a central call center, implementing screening to validate eligibility of client and trip for coverage, determining the most

	appropriate mode of transportation, maintaining quality assurance, reporting encounter data and paying transportation claims.
Call Center	A physical location where calls are received and processed for medical transportation request.
Call Center Management System	A centralized system to record, track, and monitor communications with providers, beneficiaries, and other external entities, including toll-free access for providers and beneficiaries.
Cancelled Trip	According to §380.301(7) a trip that a client cancels 4 hours before the trip takes place. Cancellation is also a verbal notification from a client's advocate using the MTP toll free number prior to the scheduled medical transportation service which indicates that the particular service is not needed.
Capitated	The method of paying an MTO a pre-determined fixed monthly amount for each Client whether or not the member receives services during the period covered by the fee and irrespective of the amount of service utilized by the Client. Payments are not adjusted for the total amount, or types, of services used by a specific Client. For example, a given Client that utilizes no services during a month will still be paid by HHSC for the full monthly capitation payment amount, and, likewise, a Client that uses a very high degree of services would be paid at no higher rate during that month. Aggregate payments to the MTO fluctuate by the number of Clients, and by any change in mix of Population Risk Groups. This payment methodology is in contrast to a fee-for-service method, in which payments are directly tied to specific services used.
Capitation Payment	The aggregate amount paid by HHSC to the MTO on a monthly basis for the provision of Covered Benefits to enrolled Clients (including associated Administrative Services) in accordance with the Capitation Rates in the Contract. HHSC calculates the Capitation Payment based on the HHSC Enrollment Files for the month, and the pre-determined fixed monthly Capitation Rates established for the period. The Enrollment Files generally change from month to month.
Capitation Rate	A fixed predetermined fee paid by HHSC to the MTO each month in accordance with the contract, for each enrolled Client in a defined Rate Cell, in exchange for the MTO arranging for or providing a defined set of services to such a Client, regardless of the amount of Covered Health Care Services used by the enrolled Client. The Capitation Rate also covers the provision of Administrative Services by the MTO. Capitation Rates may vary from one Population Risk Group to another, and from year to year, and between MTO Regions.
Children with	A program funded with general revenue and federal funds. Services for

Special Health Care Needs (CSHCN) Services Program	eligible children include early identification, diagnosis and evaluation, resulting in early heath care intervention.
Claims Administrator	An entity that contracts with the HHSC that assumes certain administrative responsibilities in support of the Title XIX Texas Medical Assistance Program (Medicaid) and other State and Federally funded programs. Also referred to as a fiscal agent.
Client	Medicaid, Children with Special Health Care Needs (CSHCN), and Transportation for Indigent Cancer Patients (TICP) clients who do not have any other means of transportation to covered, medically necessary health care services.
Code of Federal Regulations (CFR)	A codification of the general and permanent rules published in the Federal Register by the Executive departments and agencies of the Federal Government. These Federal rules direct a State in its administration of a Medicaid Program and implementation and operation of the new transportation service delivery model.
Complaint	An expression of dissatisfaction by a Client or Performing Provider, orally or in writing to the MTO or HHSC, about any matter relating to NEMT services.
Concealed Weapon	Concealed weapons are weapons, especially handguns, which are kept hidden on one's person, or under one's control.
Consolidated FSR Report or Consolidated Basis	FSR reporting results for all Programs and all Regions operated by the MTO or its Affiliates, including those under separate contracts between the MTO or its Affiliates and HHSC. Consolidated FSR Reporting does not include any of the MTO's or its Affiliates' business outside of the HHSC Programs.
Contract	The written and signed agreement resulting from this RFP for operation of the new transportation service delivery model.
Corrective Action Plan	The detailed written plan that may be required by HHSC to correct or resolve a deficiency or event causing the assessment of a remedy or damage against the MTO.
Covered Health Care Service	A covered service included in the premium of the healthcare policy paid by or on behalf of the enrolled Client.
Curb to Curb Service	Transportation from curb at origin to curb at destination. This service includes providing assistance, as required, to passengers entering and exiting the vehicle.

Deliverable	A written or recorded work product or data prepared, developed, or procured by the MTO as part of the Services under the Contract, for the use or benefit of HHSC or the State of Texas.
Demand Response	Transportation that involves using contractor dispatched vehicles in response to requests from individual or shared one-way trips.
Dependent Care	Necessary for a child or an adult with a disability.
Destination	The place or point to which a client has been authorized by MTP to travel.
Domicile Drivers	Drivers who live in their vehicles.
Early and Periodic Screening, Diagnostic, and Treatment or **EPSDT**	The Early and Periodic Screening, Diagnostic, and Treatment benefit provides comprehensive and preventive health care services for children birth through 20 years of age who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.
Encounter	A covered benefit or group of covered benefits delivered by an MTO for a client to attend a medically necessary health care event.
Encounter Data	Data elements from an MTO's capitated services proxy claims, that are submitted to HHSC by the MTO, in accordance with HHSC's required format.
Enrollment File or Eligibility File	The daily or monthly list of eligible clients that are enrolled with an MTO on the day or for the month the report is issued. Enrollment files are generated by HHSC and made available to the MTO.
Equipment	Equipment includes hardware and software that supports the processing of a call. This would include network connectivity, access to the database and equipment (operating within manufacturer's operating parameters).
Equipment Failure	Equipment failure would be an event that prohibits the functionality of the hardware or the software that supports the processing of a call from a client. This would include network connectivity, access to the database and equipment (operating within manufacturer's operating parameters).
Experience Rebate	The portion of the MTO's Net Income Before Taxes that is returned to the State in accordance with Section 6.11.3 for the Medical Transportation Program.

Fair Hearings	An informal proceeding held before an impartial HHSC hearings officer in which a client appeals a denial of eligibility, coverage, service or payment.
Fee-for-Service or FFS	The traditional Medicaid health care services payment system under which providers receive a payment for each unit of service, after the service is provided, according to rules adopted pursuant to Chapter 32, Texas Human Resources Code. This Contract does not use FFS for payment to the MTO. The term "fee-for-service" is also sometimes used to describe payments for individual services made by an MTO to Providers, according to an agreed pricing structure between those parties.
Financial Statistical Report or FSR	The FSR is a report designed by HHSC, and submitted to HHSC by the MTO in accordance with Contract requirements. The FSR is a form of modified income statement, subject to audit, and contains revenue, cost, and other data, as defined by the Contract. Not all incurred expenses may be included in the FSR.
Fixed Route	A system of transporting individuals (other than by aircraft), including the provision of designated public transportation service by public entities and the provision of transportation service by private entities, including, but not limited to, specified public transportation service on which a vehicle is operated along a prescribed route according to a fixed schedule.
Fraud	Any act that constitutes fraud under applicable federal or state law, including any intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.
Frew	Refers to the class action lawsuit: Linda Frew, et al. v. Kyle Janek, et al., U.S. District Court, Eastern District of Texas, Paris Division, Civil Action No. 3:93CV065; brought on behalf of children enrolled in Texas Medicaid through age 20
Frew class Members	Refers to Medicaid clients, birth through age 20, who have not received all of the Texas HealthSteps services to which they are entitled, unless the services were declined (see *Frew*).
FSR Reporting Period	The period of months that is measured on a given FSR. Generally, the FSR Reporting Period is a twelve-calendar-month period corresponding to the State Fiscal Year, but it can vary by contract and by year. If an FSR Reporting Period is not defined in the contract, then it will be deemed to be the twelve months following the end of the prior FSR Reporting Period.
FSR Reporting	The period beginning on the Operational Start Date and ending on

Period 15	August 31, 2015. This is the first FSR reporting Period under this contract.
FSR Reporting Period 16	The 12-month period beginning on September 1, 2015 and ending on August 31, 2016.
FSR Reporting Period 17	The 12-month period beginning on September 1, 2016 and ending on August 31, 2017.
Full Risk Capitated Provider	Transportation providers that assume the financial responsibility to provide all covered service for eligible members at the capitation rate. The Full Risk Capitated Provider is reimbursed based on the per Medicaid or other eligible enrollee per member per month payment reimbursement methodology (capitation).
Health and Human Services Commission	The oversight agency for health and human services in Texas. HHSC is the single state Medicaid and CHIP agency for Texas.
Incident	An allegation of an incident substantiated by commission records, transportation or medical provider records, and witnesses of the incident to the satisfaction of department staff.
Individual Transportation Participant (ITP)	An individual who has been approved by HHSC for mileage reimbursement at a prescribed rate to provide transportation for a prior authorized MTP client to a prior authorized heath care service.
Liquidated Damages or LDs	A pre-defined set of specific financial penalties that may be assessed against the MTO under certain pre-defined situations. Liquidated Damages will be assessed in writing against, and paid by, the MTO, for failure to meet any aspect of the responsibilities of the Contract, and/or to meet the specific performance standards identified by the HHSC in the Liquidated Damages Matrix. Liquidated Damages will be assessed if HHSC determines such failure is the fault of the MTO (including the MTO's Subcontractors, agents and/or consultants), and is not materially caused or contributed to by HHSC or its agents. At HHSC's discretion, LD's may be billed to the MTO for separate remuneration, and/or deducted from a Capitation Payment. Non-payment of an LD within 30 days of assessment may result in interest accumulating at 12% per annum, compounded daily.
Lodging	A commercial establishment enrolled with HHSC that provides overnight lodging at a negotiated rate.
Long Distance Trip	Transportation beyond a client's county of residence, county adjacent to client's county of residence, or managed care region for the purpose of receiving medical care or other health care services that are not available in the region the client resides.

Managed Care	A term denoting 1) management of member care by a provider or case manager to encourage maximum therapeutic efficacy and efficiency through service planning and coordination 2) used in reference to prepaid, capitated health care delivery systems.
Managed Transportation Organization (MTO)	A rural or urban transit district created under Chapter 458, Transportation Code; a public transportation provider defined by Section 461.002, Transportation Code; a regional contracted broker defined by Section 531.02414; a local private transportation provider approved by the commission to provide Medicaid nonemergency medical transportation services; or any other entity the commission determines meets the requirements.
Managed Transportation Region or MTO Region	A group of Texas counties included in an HHSC designated geographical area applicable to this contract. An MTO Region defines where the MTO's Clients reside (and therefore, what Clients the MTO is responsible for and gets paid for under this contract). A Region does not limit the geographical area in which an MTO may have to transport a Client under this Contract.
Managed Transportation Service Delivery	A method to provide nonemergency medical transportation using managed transportation organizations and providers, as appropriate.
Mass Transit	Public transportation by bus, rail, air, ferry, or intra-city bus either publicly or privately owned, which provides general or special service transportation to the public on a regular and continuing basis. Mass transit is intercity or intra-city transportation and also includes the use of commercial air service to transport eligible Medicaid clients to an authorized covered Medicaid service. (See fixed route).
Material Subcontract	Any contract, subcontract, or agreement between the MTO and another entity that meets *any* of the following criteria: ▪ the other entity is an Affiliate of the MTO; ▪ the subcontract is considered by HHSC to be for a key type of service or function, including o Administrative Services (including third party administrator, Network administration, and claims processing); o delegated Networks (including Transportation Services); o NEMT service providers that are paid, or are reasonably expected to be paid, $100,000 or more in any twelve-month period (and wherein any such providers that are affiliated with each other are combined for purposes of this payment measurement); o management services (including management agreements with parent); o reinsurance; o call lines (including call centers); or ▪ any other subcontract that exceeds, or is reasonably expected to

exceed, the lesser of: a) $500,000 per year, or b) 1% of the MTO's annual Revenues under this Contract. Any subcontracts between the MTO and a single entity that are split into separate agreements by time period, Program, or Region, etc., will be consolidated for the purpose of this definition.

Material Subcontracts do not include contracts with any non-Affiliates for any of the following, regardless of the value of the contract: utilities (e.g., water, electricity, telephone, Internet, trash), mail/shipping, office space, maintenance, security, or computer hardware.

Material Subcontractor — Any entity with a Material Subcontract with the MTO. Material Subcontractors may include, without limitation, Affiliates, subsidiaries, affiliated or unaffiliated third parties, and Performing Providers.

Medicaid — A health care program provided to eligible individuals under 42 U.S.C. §1396a et seq.; 42 C.F.R. §431.53 Texas Human Resource Code, Chapters 22 and 32.

Medical Transportation Program — A program which provides prior authorized nonemergency transportation services to and from covered health care services, based on medical necessity, for categorically eligible Medicaid clients enrolled in Medicaid, and eligible clients enrolled in CSHCN, or the Transportation for Indigent Cancer Patients (TICP) program who have no other means of transportation.

No Show — A term assigned to a trip when the MTO or Performing Provider waits for the client ten (10) minutes beyond the scheduled pick-up or return time. Following this ten (10) minute wait, if the client does not board the vehicle, the client may be declared a no show for the transportation service. A No Show is also a trip when the MTO or Performing Provider fails to show up for a scheduled pick-up or return.

Non-Emergency Ambulance Transportation Services — Transportation provided by ambulance in a nonemergency situation when all other means of transportation are not suitable for transporting the client to a covered medical care or other health care service. Nonemergency ambulance transportation does not include any medical monitoring, medical aid, medical care, or medical treatment during transport. No flashing lights, sirens, or emergency equipment is required. See Section 2.3.9 of this RFP for other provisions.

One-way trip — Transportation of an eligible client from point of origin to destination.
(A) Origin - The location at which the contractor is authorized to pick up the client at the start of the trip.
(B) Destination - The location or point to which a client has been authorized to travel to receive or obtain medical services.

Passenger Assistance — Assistance which enables a client to walk, enter or exit a vehicle, or transfer from a wheelchair. This does not include lifting or carrying a

	person.
Patient Control Number (PCN)	A unique numeric number assigned to a client by HHSC. Each client will have a unique PCN number.
Performing Provider	The entity that arranges or provides transportation services to an eligible MTP client, including subcontractors, independent contractors, ITP, lodging and meal vendors and intercity bus services.
Population Risk Group or Risk Group	A distinct group of Clients identified by defined criteria, which may include age, gender, type of program, eligibility category, geographical (urban or rural), or other criteria, as established by HHSC.
PMPM	Per member/client per month, or per member/client enrolled per month.
Pre-Tax Income or Net Income Before Taxes	The aggregate excess of revenues over Allowable Expenses.
Professionalism	The skill, competence, or character expected of a member of a highly trained profession.
Public Transportation	Mass transportation of passengers and their hand-carried packages or baggage on a regular and continuing basis by means of surface, fixed guide way, or underground transportation or transit, other than aircraft, taxicab, ambulance, or emergency vehicle.
Public Transportation Provider	Any entity that provides public transportation services if it is a governmental entity or if it receives financial assistance from a governmental entity, whether state, local, or federal. It does not include private carriers that do not receive financial assistance from a governmental entity.
Rate Cell	A population Risk Group for which a Capitation Rate has been determined.
Rate Period 1	The period beginning on the Operational Start Date and ending on August 31, 2015.
Rate Period 2	The 12-month period beginning on September 1, 2015 and ending on August 31, 2016.
Rate Period 3	The 12-month period beginning on September 1, 2016 and ending on August 31, 2017.
Reasonable Transportation	Transportation using the most cost-effective transportation that meets the client's medical needs: (A) within a client's local community, county adjacent to a client's

	county of residence where the client wishes to maintain an ongoing relationship with a healthcare provider of his or her choice; (B) to and from a county beyond the county adjacent to the client's county of residence when determined by HHSC to be reasonably close to obtain medically necessary, health program allowable services from a specialist when appropriate medical services are not available as specified in subparagraph (A) of this paragraph; or (C) To a provider or facility within a designated Medicaid managed care service delivery area
Regional Contracted Broker	An entity that contracts with HHSC to provide or arrange for the provision of nonemergency transportation service under the MTP.
Regional Transportation Partnership	Refers to two or more entities entering into a formal agreement to pool their respective resources to achieve a common task. Also referred to as a "consortium"
Revenue	All revenue received by the MTO pursuant to this Contract, including any retroactive adjustments made by HHSC. Revenue includes any funds earned such as investment income and earned interest. Revenue excludes any reinsurance recoveries, which shall be shown as a contra-cost, or reported offset to reinsurance expense. Revenues are reported at gross, and are not netted for any reinsurance premiums paid.
Risk or Full-Risk or Risk-based	The MTO's potential for financial losses, as a result of expenses and costs of the MTO exceeding payments made by HHSC under the Contract. The MTO is required under the Contract to provide specified Covered benefits to all Clients during the term of the Contract, irrespective of the cost incurred by the MTO. Further, the MTO faces possible fines and penalties for failure to adequately perform. The MTO also faces liability for the performance of its subcontractors. Capitation payments made to the MTO by HHSC are at a contractually fixed rate per member, per month, and are not directly tied to the expenses incurred in the period in which the payments are made to the MTO. HHSC does not reimburse an MTO for any losses incurred.
Routine Medical Transportation	Prior authorized medical transportation trips that do not have priority status to and/or from a facility where health care needs will be met.
Rural County	A Texas county that has been designated by HHSC for purposes of the Medical Transportation Program as predominately possessing rural characteristics with respect to key parameters governing the Program, including average population density per square mile, aggregate population of the county, and proximity to an urban area.
Rural Transit District	Means a political subdivision of this state that provides and coordinates rural and public transportation in its territory

Same Day Service	An urgent request for same day transportation services to an authorized provider.
Scheduling	Arranging for all transportation services covered under the contract.
Scope of Work	The description of Services and Deliverables specified in this Contract, the RFP, the MTO's Proposal, and any attachments and modifications to these documents.
Service Animal	A trained guide dog, signal dog, or other animal to provide assistance to a specified client with a disability.
Services	The tasks, functions, and responsibilities assigned and delegated to the MTO under this Contract.
Sexual Harassment	Unwelcome sexual advances, requests for sexual favors, or other unwanted verbal or physical conduct of a sexual nature directed toward an individual by another individual during the provision of MTP services
Shared Ride	A demand response transport for multiple clients traveling in the same direction with appointments scheduled within one hour of each other.
Significant Traditional Provider	An individual or entity that provides nonemergency medical transportation services and that has a documented record of providing transportation services for a minimum number of years, a minimum number of MTP clients, or a minimum number of trips. The specific levels of participation will be defined by HHSC in administrative rules to be adopted before the conclusion of the procurement.
Special Needs Transportation	Medical transportation to and/or from a client's county of residence and beyond the adjacent county, where health care needs will be met and the appropriate health care service(s) are not available locally.
Special Needs Transportation Vehicle Types	Vehicles with special equipment to meet the needs of the client to include; ramp, mechanical lift, or other device within ADA requirements. Special needs transportation includes exceptional transportation service that provides for an extraordinary medical, nonemergency circumstance (e.g., transport of the morbidly obese).
State Fiscal Year or SFY	A 12-month period beginning on September 1 and ending on August 31 the following year. Reports, Deliverables, payment rates, and other aspects of this Contract may be based in part on the SFY.
Stretcher Service	Service for clients who cannot be transported in a taxi or wheelchair van but do not require the medical services of an ambulance. Clients generally cannot use a seat in the vertical position and must use a

	stretcher during transport. Client must be medically stable to be transported by stretcher service.
Subcontract	Any agreement between the MTO and another party to fulfill the requirements of this contract.
Subcontractor	Any individual or entity, including an Affiliate, which has entered into a Subcontract with the MTO
TDD	Telecommunications Device for the Deaf.
Third Party Liability or TPL	The legal responsibility of another individual or entity to pay for all or part of the services provided to Clients under the Contract.
Third Party Recovery or TPR	The recovery of funds from an entity (or individual) that has legal responsibility to pay for all or part of a Client's Covered Benefits. For example, if a Client has insurance via a third party and the insurance coverage provides for non-emergency medical transportation in certain cases, then HHSC or the MTO (or their agents) may potentially approach the third party to collect payment as may be appropriate. Certain rules may apply as to who may pursue and/or retain TPRs under this Contract.
Transportation For Indigent Cancer Patients (TICP)	A state-funded program that provides medical transportation services to individuals diagnosed with cancer or a cancer-related illness and who meet TICP residency and financial criteria.
Transportation Provider	An appropriately credentialed and licensed individual that provides Covered benefits to the MTO's Clients. The MTO pays the Provider for Transportation Services. A Transportation Provider must enroll through the Texas Medicaid and Healthcare Partnership (TMHP) and execute a Provider Agreement before contracting with the MTO to provide transportation services.
Transportation Services	A group of activities offered through motor vehicles and ancillary provisions for eligible clients to a covered health care service.
Transportation Service Area Provider	A for-profit or nonprofit entity or political subdivision of this state that provides demand response, curb-to-curb, nonemergency transportation under the Medical Transportation Program.
Transit Service Delivery Model	A method to deliver nonemergency medical transportation by current Transportation Service Area Providers (TSAPs) in not more than three contiguous rural or small urban transit districts located within a managed transportation regions to coordinate medical transportation program service delivery activities within the area served by the providers.

Transportation Service Centers	Are also referred to as Call Centers and serves as the hub of transportation service delivery. The facilities are usually staffed with individuals knowledgeable of Medicaid covered services, clients eligibility and routes. Staff are responsible or intake, trip scheduling, trip authorization and customer service.
Trip Manifest	Pertinent trip details provided to drivers and/or performing providers prior to date of service.
TTY	Teletype writer, scribing a telegraphic apparatus by which signals are sent by striking the letter and symbols of the keyboard of an instrument resembling a typewriter and are received by a similar instrument that automatically prints them in type corresponding to the keys struck, teletype writer.
Undisputed Invoice	An undisputed invoice is a subcontractor invoice for services that were authorized by the MTO that contain no apparent errors or missing information, and may be processed by the MTO within the prescribed timeframe.
Urban County	A Texas county that has been designated by HHSC for purposes of the Medical Transportation Program as predominately possessing urban characteristics with respect to key parameters of governing the Program, including average population density per square mile, aggregate population of the county, and proximity to an urban area.
Urban Transit District	A local governmental body or political subdivision of this state that operates a public transportation system in an urbanized area with a population of more than 50,000 but less than 200,000.
Urgent Request	Urgent request is an unscheduled request due to an episodic situation in which no immediate threat to life or limb exists, but the client's treatment cannot be delayed. A request for nonemergency transportation for illnesses or injuries of a less than serious nature than those constituting emergencies but for which treatment is required to prevent a serious deterioration in client's health and for which treatment cannot be delayed without imposing undue risk on the qualified client's well-being until client secure services from regular physician.
Waste	Practices that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items, or services.

Acronyms

ACD	Automatic Call Distributor or Automatic Call Distribution
ADA	American with Disabilities Act
CAO	Corrective Action Order
CAP	Corrective Action Plan
CD	Consent Decree
CFR	Code of Federal Regulations
CMMI	Capability Maturity Model Integration
CMS	Centers for Medicare and Medicaid Services
CSHCN	Children with Special Health Care Needs
DTMF	Dual tone Multi-Frequency
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment program
FBO	Faith Based Organizations
FFS	Fee-For-Service
FSR	Financial Statistical Report
HCATS	Health and Human Services Contract Administration and Tracking System
HHSC	Health and Human Services Commission
HIPAA	Health Insurance Portability and Accountability Act
HSP	HUB Subcontracting Plan
HUB	Historically Underutilized Business
ITP	Individual Transportation Participant
IVR	Interactive Voice Response Unit or Intelligent Voice Response Unit
KPR	Key Performance Requirements
LOMN	Letter of Medical Necessity
MCD	Medicaid/CHIP Division
MCO	Managed Care Organization
MTO	Managed Transportation Organization
MTP	Medical Transportation Program
NEMT	Nonemergency Medical Transportation
OIG	Office of Inspector General
PA	Prior Authorization
PAN	Prior Authorization Number
PHI	Protected Health Information
PMPM	Per Member/Per Month
POS	Point of Service
PPM	Policies and Procedures Manual
RCB	Regional Contracted Broker
RFP	Request for Proposal
RTN	Routine Transportation
SAO	State Auditor's Office
SAR	State Action Request
SMT	Special Medical Transportation
SPA	State Plan Amendment
SSN	Social Security Number
TAC	Texas Administrative Code
TDD	Telecommunications Device for the Deaf
THSteps	Texas Health Steps
TICP	Transportation for Indigent Cancer Patients

TIERS	Texas Integrated Eligibility Redesign System
TMHP	Texas Medicaid Healthcare Partnership
TMTS	Texas Medical Transportation System
TDI	Texas Department of Insurance
TTY	Teletype writer

Attachment C
Health and Human Services Commission
Nonemergency Medical Transportation Request for Proposal
Eligibility, Utilization and Cost Experience

The following exhibits present information regarding the Texas Health and Human Services Commission's (HHSC) Nonemergency Medical Transportation (NEMT) program experience. The exhibits contain NEMT program eligibility, utilization and financial experience by service area and eligibility category. This dataset is intended to present prospective NEMT vendors with the information necessary to evaluate vendor staffing levels, program utilization and expected cost.

Please note that HHSC implemented a full risk managed NEMT arrangement in the Houston area in March 2012 and in the Dallas/Fort Worth area in April 2012. Prior to that time, NEMT services were provided in Houston and Dallas/Fort Worth under a fee-for-service (FFS) arrangement. A FFS arrangement continues in the remainder of the state. The utilization and financial experience information presented in this attachment includes only FFS experience.

Please note that these exhibits have been prepared based on information from various sources. It is the opinion of program staff and HHSC's consulting actuary that these reports present an accurate picture of NEMT program experience.

The following definitions are used throughout this Attachment.

Managed Transportation Organization (MTO) Regions. MTO Regions are the service areas defined in Attachment A of the RFP.

MTO Rate Cell. Rate Cells are the NEMT program eligibility categories used to define the capitation rates payable to the selected vendors. MTO Rate Cells are described in Section 6.10 of the RFP.

Fiscal Year. The state fiscal year (or FY) begins on September 1 and ends on August 31.

Exhibit 1: This exhibit presents average monthly NEMT program eligibility by MTO Region, county, fiscal year and MTO rate cell. The report contains historical program eligibility for the period FY2010 through FY2013 and a projection of future eligibility through FY2017. The eligibility information presented is based on experience through August 2013.

Exhibit 2: This exhibit presents March 2013 NEMT program eligibility by MTO Region, county and Medicaid eligibility category (or risk group). This report is intended to provide the prospective vendor with a more detailed picture of the eligible population in each MTO Region.

Exhibit 3: This exhibit presents the number of unique clients utilizing NEMT program services during the June 1, 2012 through May 31, 2013 experience period by county, service category and

rate cell. A client is counted only once in each service category but may be included in multiple service categories.

Exhibit 4: This exhibit presents the number of trips for Demand Response and Individual Transportation Participants service categories during the June 1, 2012 through May 31, 2013 experience period by county and rate cell. Exhibit 4A presents utilization for the Demand Response service category and Exhibit 4B presents utilization for the Individual Transportation Participants service category. The number of trips represents a trip leg, not a round trip. For example, a client transported to a doctor's office, then to a pharmacy, and then back home would be three trips. The number of trips shown on these reports represents paid claim's experience. These reports do not include no-shows or cancelled requests.

Exhibit 5: This exhibit presents the distribution of mileage per trip for Demand Response and Individual Transportation Participants service categories during the June 1, 2012 through May 31, 2013 experience period by MTO Region and age category. Exhibit 5A presents information for the Demand Response service category and Exhibit 5B presents information for the Individual Transportation Participants service category. The number of trips represents a trip leg, not a round trip. For example, a client transported to a doctor's office, then to a pharmacy, and then back home would be three trips. The number of trips shown on these reports represents paid claim's experience. These reports do not include no-shows or cancelled requests. For Exhibit 5A, the number of miles per trip is an estimate from origin to destination using Google Maps. Trips without miles recorded (approximately 10% of Demand Response trips) are excluded from this report.

Exhibit 6: This exhibit presents the number of trips by type of professional appointment for Demand Response and Individual Transportation Participants service categories during the June 1, 2012 through May 31, 2013 experience period by MTO Region and age category. Exhibit 6A presents the number of trips for the Demand Response service category for children ages 20 and under. Exhibit 6B presents the number of trips for the Demand Response service category for adults ages 21 and over. Exhibit 6C presents the number of trips for the Individual Transportation Participants service category for children ages 20 and under. Exhibit 6D presents the number of trips for the Individual Transportation Participants service category for adults ages 21 and over. The number of trips represents a trip leg, not a round trip. For example, a client transported to a doctor's office, then to a pharmacy, and then back home would be three trips. The number of trips shown on these reports represents paid claim's experience. These reports do not include no-shows or cancelled requests.

Exhibit 7: This exhibit presents the number of trips by type of special need for the Demand Response service category during the June 1, 2012 through May 31, 2013 experience period by MTO Region and age category. Exhibit 7A presents the number of trips for the Demand Response service category for children ages 20 and under. Exhibit 7B presents the number of trips for the Demand Response service category for adults ages 21 and over. The number of trips represents a trip leg, not a round trip. For example, a client transported to a doctor's office, then to a pharmacy, and then back home would be three trips. The number of trips shown on these reports represents paid claim's experience. These reports do not include no-shows or cancelled requests.

Exhibit 8: This exhibit presents NEMT program service cost experience by MTO Region, county, fiscal year and MTO rate cell for the period FY2010 through FY2013. The service cost amounts are allocated to fiscal year of incurral. The report includes service cost payment amounts through September 6, 2013. As a result, FY2013 experience is incomplete.

Please note that on June 1, 2012, HHSC implemented the Travel Expense policy. This policy reduced or eliminated the authorization of Advanced Funds to clients. Prior to implementation of the new policy Advance Funds expenditures amounted to around $5 million per month. Since clients may no longer (for the most part) receive advance funds, they may use other modes of NEMT program services such as Demand Response or Mileage Reimbursement.

Exhibit 9: This exhibit presents NEMT program service cost experience by service category, service (incurral) month and payment month for the period March 2012 through August 2013. This report is intended to provide the prospective vendor with the information necessary to properly evaluate the most recent fiscal year (FY2013) of experience.

Exhibit 10: This exhibit presents NEMT program service cost experience by MTO Region, county and service category for services incurred during the period June 1, 2012 through May 31, 2013.

Exhibit 11: This exhibit presents NEMT program service cost experience by MTO Region and eligibility category for services incurred during the period June 1, 2012 through May 31, 2013. Program eligibility includes a small group of clients in MTO Region 10 known as Transportation for Indigent Cancer Patients (TICP) Program and described in Texas Administrative Code, Title 1, Part 15, Chapter 380. Currently there are around 90 clients enrolled in the TICP program. This report is intended to provide some guidance regarding the anticipated utilization and cost of the TICP clients. Detailed utilization and cost data by county is not available for these clients.

Exhibit 12: This exhibit presents monthly NEMT program call center activity by county and city for September 2012 through August 2013. For each month, the report shows the (i) number of unique callers, (ii) the total number of calls, (iii) the number of completed calls and (iv) the average length of a completed call.

Attachment D – Parental Accompaniment Form

TEXAS
Health and Human Services Commission

MTP01 Parent Authorization Form
September 10, 2013 Doc375001

Medical Transportation Program Parent Authorization Form

Child Name:	Medicaid Number:
Date of Birth:	Type of Program: ☐ CSHCN ☐ Medicaid

My name is _____. I am the parent or legal guardian of the child named above.
I have asked the Medical Transportation Program to set up rides to get my child to and from health-care services covered by Medicaid or the CSHCN program. In the chart below I am listing facts about me and other adults I have chosen to be "attendants." These adults are authorized to go with my child to and from Medicaid or CSHCN-covered health-care visits.

	Attendant	First, Middle, Last Name	Address	Phone Number
1	Parent ☐ Guardian ☐			
2	Parent ☐ Guardian ☐			
3	Authorized Attendant 1			
4	Authorized Attendant 2			

Sample

It is my choice to authorize these people to be attendants. By signing this form, I'm showing that I know the risks that go with allowing another person to travel with my child on health-care trips set up through the Medical Transportation Program. I know this agreement will stay in effect until I change or replace it.

_____ _____
Signature of Parent or Legal Guardian Date

Two things must happen before the authorized attendants listed above can ride with the child to and from the covered health-care services:

1) This form must be on file with the Medical Transportation Program or be given to the driver when the driver picks up the child for the health-care visit.
2) The authorized attendant also must show the driver a photo ID.

Fill out and mail this form to: MTP-MC 0209, PO Box 149030, Austin, TX 78714-9030
OR
Fill out and fax this form to: 1-855-671-6044

Attachment E – Training Requirements

Training Subject	Training Frequency Required Prior to the implementation of the contract and as noted below
ADA training	Every 2 years
Basic First Aid	Every 3 years
Civil Rights	Every 2 years
Claims Processing Requirements	As needed
Client Rights and Responsibilities	Annually
Contract Applicable Laws including the Texas Prompt Payment Law (Key Personnel required)	Annually
Court Ordered Requirements (Section 2.35.3) Instruction and Training Updates	Annually
Customer Service	Annually and as needed
Dealing with clients with behavior and/or violent behaviors	Every 2 years
Defensive Driving	Every 2 years
MTO Operating Procedures	Annually
MTO Quality Assurance Plan	Annually
HHSC Automated Systems	Annually
HIPAA Training	Annually
Orientation Familiarization of the Medical Transportation Program (MTP) Nonemergency Transportation	Annually
Passenger Assistance Techniques	Annually
Trip documentation (Signature logs)	Annually
Transfer and proper restraint of mobility devices including scooters	Annually
Service Delivery	Annually
When and How to Call for Emergencies	Annually
Additional contractor training	As needed

Attachment F – Community Organization Resources

Faith-Based Organizations Resource
http://www.yourcommunityguide.org/community/

Your Community Guide
http://www.yourcommunityguide.org/
http://www.yourcommunityguide.org/community/

The Governor's Faith-Based and Community Initiative
OneStar promotes service and volunteerism, forges effective public and private partnerships, and works to increase the performance of non-profit organizations.

Website: http://onestarfoundation.org/

Texas Transportation Association: http://texastransit.org

Texas Public Transportation Agencies: http://www.txdot.gov/inside-txdot/division/public-transportation.html

Texas Nonprofit Resources

- http://www.sos.state.tx.us/corp/nonprofit_org.shtml
- Texas Association of Nonprofit Organizations: A gathering place for all nonprofits within the state of Texas.
- Texas Nonprofit Management Assistance Network: An association of providers identifying and meeting the needs of Texas Nonprofits.
- Texas Business Advisor: The Texas Business Advisor provides links to various sites that may be of assistance to non-profit associations.
- Charitable Trust Section of the Office of the Attorney General
- Texas C-BAR: Community Building with Attorney Resources provides free legal assistance to Texas non-profit organizations.

Attachment G – Other Resources

THMP Companion Guide:
http://www.tmhp.com/EDI%20Companion%20Guides/Acute%20Care/Version%205010/837P%20ACUTE%20CARE%20COMPANION%20GUIDE_5010.pdf

EDI Technical Information:
http://www.tmhp.com/Pages/EDI/EDI_Technical_Info.aspx

Additional Companion Guidelines:
http://www.tmhp.com/Pages/EDI/EDI_companion_guides.aspx

Attachment H - MTO Disclosures and HHSC Requirements

Medicaid Assurance and Certification
Provider Financial and Criminal Disclosure Requirements
Criminal Background Checks
HIPAA Requirements
Transmission Security
Device and Media Control
Business Associate Agreement

Medicaid Assurance and Certification

The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), requires certain application and disclosure information as required under Title 42, Public Health 455.1 Basis and Scope, to include but not limited to requirements for a State fraud detection, and investigation program, and for disclosure of information on ownership and control.

Provider Financial and Criminal Disclosure Requirements

The U.S. Department of Health and Human Services, CMS requires certain application and disclosure information as required under 42 CFR Part 455, Program Integrity: Medicaid; 42 CFR Part 455.104 Disclosure by providers and fiscal agents: Information on ownership and control; 42 CFR Part 455.105 Disclosure by providers: Information related to business transactions. HHSC requires compliance with these legal changes in all of its vendor agreements.

MTO agrees to disclose information on ownership and control, information related to business transactions and information on persons convicted of crimes in accordance with 42 CFR Part 455, Subpart B, and provide such information on request to the Texas Health and Human Services Commission (HHSC), Department of State Health Services (DSHS), Texas Attorney General's Medicaid Fraud Control Unit, and the United States Department of Health and Human Services. This disclosure is required of all Providers. MTO agrees to keep its application for participation in the Medicaid program current at all times by informing HHSC or its agent in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, phone number, or provider business addresses, at least 10 business days before making such changes. MTO also agrees to notify HHSC or its agent within 10 business days of any restriction placed on or suspension of the MTO's license or certificate to provide medical services, and MTO must provide to HHSC complete information related to any such suspension or restriction.

MTO agrees to disclose all convictions of MTO or MTO's principals within 10 business days of the date of conviction. For purposes of this disclosure, MTO must use the definition of

"Convicted" contained in 42 CFR 1001.2, which includes all convictions, deferred adjudications, and all types of pretrial diversion program. Fully explain the details, including the offense, the date and state and county where the conviction occurred and the cause number(s).

Criminal Background Checks (CBC)

The MTO shall conduct or cause to be conducted for each new employee, employee, subcontractor, subcontractor employee who works directly with clients under this contract, or who have direct access to client records, a state Internet Computerized Criminal History file (CCH) background check through the Department of Public Safety's public internet website, a National CCH from an organization that is nationally approved and recognized to provide criminal history background checks, and a National and State Sex Offender Registry check, which shall be maintained by the MTO, available for review by the HHSC.

The MTO must submit the name of the nationally approved and recognized organization it elects to use for the national criminal history and background check to HHSC for approval. The MTO shall check for felony and misdemeanor convictions for the seven years prior to the hire date and annually thereafter. Individuals with any criminal conviction that falls within the aforementioned categories that occurred within seven years prior to the hire date or any time after the hire date shall not be allowed to participate in providing requirements of the contract and any services that are determined to have been provided by a person not eligible to provide services under this contract will be recouped.

Information on CCH can be found at:

The Texas Department of Public Safety
https://records.txdps.state.tx.us/DPS_WEB/Portal/index.aspx

National and State Offender Registries can be found at:

National: http://www.nsopw.gov
State: https://records.txdps.state.tx.us/DPS_WEB/SorNew/index.aspx

Drivers must not have any findings by a law enforcement authority of driving while intoxicated (DWI/DUI) or under the influence of any substance that may impair the driver's ability to safely operate a motor vehicle within seven years prior to the initial hire date or any time after the hire date. Any driver who is convicted of DWI/DUI after the hire date is immediately ineligible to provide services under this contract for a period of seven years after the date of conviction.
Drivers must not have a felony or misdemeanor conviction within seven years of the initial hire date or any time after the hire date of:

(a) an act of abuse, neglect or exploitation of children, the elderly or persons with disabilities as defined in Texas Family Code, as amended, Chapter 261 and Texas Human Resources Code, as amended, Chapter 48; or

(b) an offense under the Texas Penal Code, as amended, against the person; against the family; against public order or decency; against public health, safety or morals;

against property; an offense under Chapter 481 of the Texas Health and Safety Code, as amended, (Texas Controlled Substances Act).
Drivers must not have been found to have conducted or participated in any acts prohibited by the Texas Human Resources Code Chapter 36.

The MTO must require each performing provider providing any NEMT service who works directly with clients or has access to client records, under this contract to notify the MTO in writing, within ten business days, of criminal convictions (felony or misdemeanor) and pending felony charges or placement on a Registry as a perpetrator. This is an ongoing requirement during the term of the contract.

The MTO must require each performing provider providing any NEMT service who works directly with clients or has access to client records under this contract who has not resided or lived in Texas to sign a waiver attesting to the fact they have never been convicted of a felony or misdemeanor referenced in the above paragraph Criminal Background Checks (CBC) or identified as a perpetrator. If they have been convicted, the nature and conviction date of the felony or misdemeanor must be disclosed.

The MTOs must certify that the services will not be assigned to demand response drivers who have an employment contra-indicator finding on CCH and or Registry.

The MTO must have a written policy describing the criteria on which the determination was made, and must document the basis for each determination for subcontractors providing demand response service. Additionally, the MTO must have a written policy regarding acceptable screening practices of new employees who have direct access to client and or client records, which serve to protect the organization and its clients that is clearly defined. The MTO must ensure that any subcontractors have this written policy is enforced.

If MTO determines that an employee, subcontractor, or subcontractor employee who provided demand response services under this Contract for any period prior to completion of the required checks as described above, HHSC will assess liquidated damages.

HIPAA Requirement

Electronic communication must be compliant with Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) (42 U.S.C. §§1320d-1320d-8) as amended by The Health Information Technology for Economic and Clinical Health (HITECH), American Recovery and Reinvestment Act (ARRA) of 2009 at Title XIII of Division A and Title IV of Division B. security requirements concerning electronic transport of client information. The MTO must have an operational electronic mail system to receive and respond to encrypted transportation requests. Under no circumstance should client information be sent unsecured by electronic mail.

The MTO must ensure that the names and any other identifying information on eligible clients served under this service are not released by the MTO without prior, written permission from

HHSC. All client specific information is confidential under state and federal law. This provision must not be construed as limiting access to client specific information by the State of Texas, to include HHSC, Office of the Attorney General, Medicaid Fraud Control Unit, or the US Department of Health and Human Services. This provision does not authorize the MTO to obstruct a proper fraud or criminal investigation.

Transmission Security

Transmission Protocol: Communication must be secure from end to end, necessitating the use of encryption. Valid encryption processes for data in motion are those which comply, as appropriate, with NIST Special Publications 800-52, Guidelines for the Selection and Use of Transport Layer Security (TLS) Implementations; 800-77, Guide to IPsec VPNs; or 800-113, Guide to SSL VPNs, or others which are Federal Information Processing Standards (FIPS140-2 validated).

Device and Media Control

Data Destruction: The media on which protected health information (PHI) is stored or recorded has been destroyed in one of the following ways:

- Paper, film, or other hard copy media have been shredded or destroyed such that the PHI cannot be read or otherwise cannot be reconstructed. Redaction is specifically excluded as a means of data destruction
- Electronic media have been cleared, purged, or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization such that the PHI cannot be retrieved.

HHSC Uniform Contract Terms & Conditions, Version 1.4, Article 16. Special Terms and Conditions, Section 16.01 HIPAA, apply to this contract.

Business Associate Agreement (BAA)

All subcontractors must have a Business Associate Agreement on file at the MTO's managing office in Texas.

Attachment I – Material Subcontractor Screening Requirements

The MTO must review the following before contracting with a material subcontractor to administer services. These requirements are applicable to demand response, lodging, and meal providers.

System for Award Management (SAM)

The System for Award Management (SAM) is the Official U.S. Government system that consolidated the capabilities of CCR/FedReg, ORCA, and EPLS. SAM is an electronic web based system that identifies those parties excluded from receiving federal contracts, certain subcontracts, and certain types of federal financial and non-financial assistance and benefits.

Web site: https://www.sam.gov/portal/public/SAM/

About Texas HHSC OIG Exclusion Program

Texas Health & Human services Commission (Commission), Office of Inspector General (OIG) works diligently to protect the health and welfare of the Texas Medicaid's and other HHS program's recipients by preventing certain individuals and businesses from participating in health care programs. The OIG excludes individuals and entities affected by various legal authorities. A listing of all currently excluded parties is maintained by OIG and is called the List of Excluded Individuals/Entities by Texas OIG.

Bases for exclusion include convictions for program-related fraud and patient abuse, licensing board actions, U.S. Health & Human Services OIG (Medicare) exclusion actions, and "Permissive" exclusions as allowed by various legal authorities.

It is each provider's or person's responsibility to ensure that items or services furnished personally by, at the medical direction of, or on the prescription or order of an excluded person are not billed to the Titles V (Maternal and Child Health Services), XIX (Medicaid), XX (Block Grants for Social Services), and/or other HHS programs after the effective date of exclusion. This section applies regardless of whether an excluded person has obtained a program provider number or equivalent, either as an individual or as a member of a group, prior to being reinstated.

Failure to ensure excluded providers are not participating in the activities above and/or billing for services rendered by an excluded person will result in exclusion of the currently active providers and persons allowing the forbidden activity, plus recoupment of all funds paid to the currently active provider or person for those activities, and imposition of damages and penalties against both the currently active provider or person and the excluded person. The damages and penalties are delineated in 1 TAC §371.1721 et seq. of this subchapter.[1]

The effect of exclusion[2] from Medicaid, Title V, and Title XX and other HHS programs is as follows:

• No payment will be made by these programs for any item or service furnished by the exclude person on or after the effective date of exclusion;

• The excluded person must neither personally nor through a clinic, group, corporation, or other association or entity, bill or otherwise request or receive payment for any Title V, XIX, or XX, or other HHS programs for items or services provided on or after the effective date of the exclusion. Exclusion also prevents the excluded person from providing any services pursuant to the Medicaid program, whether or not you directly request Medicaid program payment for such services;

• The excluded person must not assess care or order or prescribe services, directly or indirectly, to Title V, XIX, or XX, or other HHS programs recipients after the effective date of exclusion. A clinic, group, corporation, or other association or entity must not submit claims for any assessments, services or items provided by a person within such organization or entity who is excluded from participation, unless the services or supplies were provided before the effective date of exclusion;

• An entity that employs or otherwise associates with a person excluded from participation in Titles V, XIX, or XX, other HHS programs must not include within a cost report or any documents used to determine an individual payment rate, a statewide payment rate or a fee, the salary, fringe benefits, overhead, or any other costs associated with the person excluded;

• An order or prescription written before the exclusion effective date is valid for the duration of the order or prescription; and

[1] See 1 Texas Administrative Code (TAC) §371.1677(a)
[2] See 1 TAC §371.1673 “Scope and Effect of Exclusion”

• An order or prescription written before the exclusion effective date is valid for the duration of the order or prescription; and

• If, after the effective date of an exclusion, claims are submitted or are cause to be submitted for services or items furnished within the period of exclusion, administrative damages and/or penalties may be imposed.[3]

Comptroller of Public Accounts Vendor Debarment

The CPA may debar a vendor for a period that is commensurate with the seriousness of the vendor's action and the damage to the state's interest. A vendor's name may be removed from the CPA's Centralized Master Bidders List for the same period. At a minimum, the number and severity of a vendor's performance problems in relation with volume of goods or services provided, the effectiveness of corrective actions taken by the vendor, and the age and relevance of past performance information at the time it is used shall be considered. When in the best interest of the state, a business entity or a successor-in-interest may be debarred for any of the following:

1. A history of unsatisfactory performance of a contract, or a history of failure to perform contracted services.
2. Stating an unwillingness to honor a binding bid.
3. Knowingly and intentionally supplying false information in order to appear responsive to a solicitation, to obtain a contract, or to qualify for a bid preference.
4. Knowingly and intentionally conferring or offering to confer any gift, gratuity, favor, or advantage, present or future, upon any employee of a state agency who exercises any official responsibility for an acquisition.
5. Conviction of any felony charge of fraud, bribery, collusion, conspiracy, federal or state antitrust laws, or other criminal offense in connection with the bidding upon, award of, or performance of any contract for goods and services with any state agency.
6. Violation of state ethic laws.
7. Failure to comply with terms and conditions of existing contracts.
8. Notice of debarment activities from other governmental entities.
9. Any cause indicating that the individual or firm is not a responsible vendor.

In addition, a proposed debarment may include all known successors-in-interest of a business entity. Each proposed decision to debar a vendor and/or successors-in-

[3] See Social Security Act §§ 1128(a) (1) (D), 1128B (a) (3), 1 TAC §§ 371.1721-371.1741, and Texas Human Resources Code § 32.039
Website: https://oig.hhsc.state.tx.us/Exclusions/Search.aspx

interest shall be made on a case-by-case basis after consideration of relevant facts and circumstances. A proposal to debar a vendor shall be delivered in writing to the vendor's address of record. The proposal will state the reason(s) of the debarment action. Vendors subject to a proposed debarment may submit a written appeal to the Director of Procurement within ten (10) business days following notification of the proposed debarred status. Debarment does not relieve the vendor of responsibility for existing contractual obligations with the state. No person who has a direct interest in the outcome of the appeal may communicate directly or indirectly upon the merits of debarment with any CPA employees without notice and approval of the Director of Procurement. The CPA and all state agencies shall ensure that debarred vendors do not participate in any further state contracting. Any exclusion from state contracting due to debarment shall extend to all state contracting and subcontracting within the supervision of state agencies.

Website:http://www.window.state.tx.us/procurement/prog/vendor_performance/debarred/

Comptroller of Public Accounts Certificates of Account Status
A Certificate of Account Status certifies that a taxable entity doing business in Texas is in good standing with its franchise tax reports and payments, or that the entity is exempt from the state franchise tax. A Certificate of Account Status may be required in order to conduct real estate or financial transactions.

Web Site: http://ecpa.cpa.state.tx.us/coa/coainst.html

Texas Secretary of State (SOS)
Uniform Commercial Code Web Services Overview

General Information
Financing Statements, Utility Security Instruments, Federal Liens, Restitution Liens, Agricultural Liens, Contract Agricultural Liens, Transmitting Utilities, Manufactured-Home Transactions, Public-Finance Transactions, Aircraft Maintenance Liens, and Transition Property Notices are filed with the Uniform Commercial Code Section of the Office of the Secretary of State. Certain information taken from the initial filing and any subsequent filed documents are maintained in the BEST (Business Entity and Secured Transactions) database. Data includes: Debtor name and address, Secured Party name and address, filing date, expiration date, initial filing type, amendment filing type, and collateral description.

The Agency provides a business-to-government e-commerce service for the submission of bulk electronic filings using extensible Markup Language (XML). The Uniform Commercial Code (UCC) Web Service provides a means to file Financing Statements

(UCC1) and Financing Statement Amendments (UCC3) and to submit Information Requests (UCC11) to the UCC Section through the Internet. An organization can use this service to submit UCC filings to the Office of the Secretary of State of Texas once they have opened a SOSDirect account. The transmitted SOAP (Simple Object Access Protocol) envelope will contain two objects – a Client Data Object identifies the service company and specifies the payment method for application fees and a UCC Filing Data Object contains the application data for a collection of UCC applications. The status of previously submitted envelopes may be checked on the SOSDirect website.

Web Site: https://direct.sos.state.tx.us/help/help-ucc.asp?pg=bulk#info
Web Site: https://direct.sos.state.tx.us/acct/acct-login.asp

Attachment J – Contract Required Reports

Contract Required Reports		
Report to HHSC	**Reporting Method**	**Due to HHSC**
ADMINISTRATIVE		
Documentation outlining the skills and qualifications of key personnel	Fax or Email	Prior to hiring key personnel
Letters of reference for the key personnel	Fax or Email	Prior to hiring key personnel
Report changes in contact personnel	Telephone or email	Within five workdays of the change
Medical providers' documentation supporting clients' needs when applicable	In client file	As requested
Lists and certificates of completed trainings for MTO staff and subcontractors	In Staff/Subcontractor File	Annually
Staff monitoring forms, throughout the term of the contract	On file	As requested
Evidence of drug testing and criminal background checks	In Staff File	Annually
Report email address or phone number changes	Telephone or email	Immediately
Provide policy manual and updates	On file	As requested
Report of subcontractor payments	Email	On the 15th day of the following month (example: June 2013 would be submitted by close of business on July 15, 2013)
CLIENT REPORTS		
Client referrals for community services	In client file	As requested
List of completed community forums to educate providers and clients about the MTO services	On file	As requested
Report of annual mailing to clients in the assigned MTO regarding the program	On file	As requested

Contract Required Reports		
Report to HHSC	**Reporting Method**	**Due to HHSC**
Report that clients received copies of their rights, responsibilities, and transportation procedures	On file	As requested
Copies of all Written Notice Form issued for client sanctions	On file	As requested
SERVICES		
Monitor the frequency of authorizations of services involving excessive distance per client	On file	As requested
Document all trip requests	In system	As requested
Reports of Global Position Systems (GPS) to record pick up and drop off times for each destination	In file or system	As requested
Determination of appropriate travel type for clients	On file	As requested
Report on monitoring activities, monitoring findings, corrective actions taken and improvements made	On file	Monthly
Report of number of client add-on trips	On file	Within 95 days of occurrence
Report denial of services	On file	As requested
Report any problems that affect the delivery of transportation services and require implementation of the contingency plan	Telephone or email	Immediately followed with written report
Trip Counts by Mileage 1. 10 miles or less; 2. 11 miles to 25 miles; 3. 26 miles to 50 miles; 4. 51 miles or greater	In system	As requested
COMPLAINTS		
Automated report and documentation of complaints received	Email	Monthly or as requested
TELECOMMUNICATION		
Scheduled reports are found in §2.6, §2.9.11 and §2.19.12	TBD	As indicated in the RFP
Encounter Data Report (RFP Section 2.25)	Format and Media Prescribed	Monthly to the fiscal agent by the 30th day after the last day of the month
Performing Provider		

Contract Required Reports		
Report to HHSC	**Reporting Method**	**Due to HHSC**
Current active roster of Performing Provider for the TSA and continue to identify and update new or existing Performing Providers information	Fax or email	As updated
Notify HHSC in writing regarding the termination, suspension or reinstatement of Performing Provider	Fax or email	Within three business days from the date the action is taken
Current active roster of drivers for demand response services	Fax or email	Quarterly
Current active roster of vehicles used for demand response services	Fax or email	Quarterly
Performance reports for Performing Provider	Email documents	Monthly
Maintain Performing Provider required documents	On file	As requested
Documentation on ITPs enrollment requirements	In ITP file	As requested
Prime Contractor Progress Assessment Report	Fax or email	Monthly
Financial and Related Reports (as described in the RFP and its Attachments)		

Attachment K –Cost Principles for Expenses

Applicability of the Cost Principles for Expenses

This document is part of the Contract, and applies to Managed Transportation Organizations (MTOs) participating in the HHSC Medical Transportation Program (MTP) for nonemergency medical transportation under Medicaid. It also applies to any other Texas Medicaid or CHIP capitated full-risk contract that may reference these specific Cost Principles. Certain other HHSC Programs have different versions of the Cost Principles that apply specifically to the given Program. The differences may be significant in places.

I. General

A. Introduction

This document, Cost Principles for Expenses, contains principles establishing the allowability or unallowability of administrative expenses, reinsurance expenses, subcontract expenses, medical transportation owned-fleet operating expenses, and other expenses relative to the Managed Transportation Program (MTP) Financial Statistical Reports (FSRs). The allowability or unallowability of expenses impact the calculation of FSR-reported net income, and consequently may affect the experience rebate calculated in accordance with the Contract's requirements. These principles apply to both direct and indirect costs. A cost is allowable only to the extent of benefits received by HHSC under the Contract, and to the extent that the cost conforms to the policies, principles, and requirements of these Cost Principles.

All costs reported by MTOs on the FSR are subject to the cost allowability requirements under these Cost Principles. Until audits are completed on 120-day FSRs (and any corresponding adjustments are made to FSRs), amounts are subject to revision by HHSC for appropriate reporting on the FSR, according to the Cost Principles. This may in turn impact calculations or payments for Experience Rebates on prior periods.

B. Relevance of the Federal Acquisition Regulations (FAR) and Office of Management and Budget Circular A-122 (OMB A-122)

All costs, fees, assessments, Affiliate transactions, and Subcontracts are subject to the allowability tests and requirements as set forth in the FAR (48 C.F.R Part 31) and OMB Circular A-122, except where HHSC specifically allows an exception as documented in this the Cost Principles or other Contract language. Any such exception must be specifically noted as an exception to FAR or OMB A-122. In case of any conflicts between the Contract and any language from FAR, OMB A-122, or Generally Accepted Accounting Principles (GAAP), the Contract prevails. If there is a conflict between the principles, regulations, or requirements of GAAP versus those of FAR or OMB A-122, then FAR or OMB A-122 prevails.

Regulatory language involving a CMS exemption of applicability of FAR or OMB Circulars to Medicare will not overrule the Cost Principles.

For purposes of applying FAR to the MTO Contract, "at risk" contracts (such as Medicaid/CHIP capitation arrangements) will be Fixed Price contracts in FAR terminology, whenever FAR distinguishes between Fixed Price and Cost Reimbursement contracts.

C. 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 MTOs for these same expenses or costs, even if the state did not previously disallow those expenses. Going forward, the state would deem any similar expenses or costs unallowable. If the state retroactively recoups money from the MTOs due to a federal disallowance, the state will recoup the entire amount paid to the MTO for the federally disallowed expenses or costs, not just the federal portion.

D. Affiliate transactions and Affiliate cost reporting

The requirements of the Cost Principles prevail over all FAR, OMB A-122, GAAP, and any other regulatory or Contract language regarding "fair and equitable," "reasonable," or similar terms that refer to pricing between Affiliates.

For FSR reporting, profits made by an Affiliate due to the MTO's Contract must be attributed as profits to the MTO Contract, even if the profits are reasonable. Narrowly-defined exceptions to this rule are identified in Section I(D)(3), "Exceptions to Affiliate cost-based reporting." Affiliates may make profits on the MTO Contract, but they must be labeled and reported to HHSC accordingly by the MTO, and not converted to an MTO "cost" for FSR reporting purposes.

For FSR reporting, fees paid by an MTO to an Affiliate are allowable only at the Affiliate's actual cost, except as described in Section I(D)(3), below.

(1) FSR reporting requirements for Subcontractors, including Affiliates. Terms of the MTO Contract apply to any MTO Subcontracts. Consistent with the MTO's affirmative duty to not include its own unallowable costs in FSR reporting, the MTO is responsible for segregating any unallowable Affiliate costs for FSR reporting purposes. The "full cost" from an Affiliate does not generally include Affiliate profit labeled as an MTO cost. Costs incurred by affiliated Subcontractors are subject to the same allowability tests as the MTO's costs, and therefore, may be disallowed for FSR reporting purposes.

HHSC's right to obtain and review financial and cost documents extends to Subcontractors, including the right to: (1) examine supporting documentation for cost build-up in Affiliate Subcontracts; (2) review a Subcontractor's income statement; and (3) segregate, within the income statement, certain revenue and cost categories by those attributable to the MTO Contract versus all other revenues and costs. At

HHSC's direction, the MTO may be required to file a separate FSR for an affiliated Subcontractor. Any findings by HHSC or its auditors will not affect the Affiliate's books, records, or financial reporting; findings would only apply to the MTO's FSR reporting.

(2) Subcontract submission/notification: relevance to cost reporting allowability rules. HHSC's review of a Subcontract or Affiliate agreement will not be construed as a determination that a cost or expense is allowable under state or federal laws, rules, or regulations, or the requirements of the MTO Contract, including the Cost Principles. Subcontracts are not exempt from audit and must conform to the Cost Principles.

Any approval of a Subcontract or Affiliate agreement by a regulatory agency other than HHSC does not overrule the terms of the MTO Contract. Thus, any approval of costs or transaction types by the Texas Department of Insurance (TDI) may be applied to the MTO's reporting to and compliance with TDI requirements, but does not provide exemption from the Cost Principles.

(3) Exceptions to Affiliate cost-based reporting. An exception to the rule regarding Affiliate cost reporting occurs when an Affiliate has routine sales to multiple unaffiliated third parties, selling standard items or services ("Comparable Unaffiliated Sales"). In these cases, external prices for interchangeable items or specific services would be comparable.

This exception does not apply to parental administrative services agreements or Affiliate reinsurance.

Use of the Comparable Unaffiliated Sales exception in FSR reporting of Affiliate costs must receive HHSC's prior written approval, but approval does not exempt the approach from audit. To request the Comparable Unaffiliated Sales exception for FSR reporting, the MTO should submit supporting documentation to HHSC, such as names of specific unaffiliated entities that are sold to, prices to each, timeframe, and the comparability of the services being sold and priced. To make a determination, HHSC or its designee may require the MTO to submit information regarding sales classifications and price lists or contracts documenting pricing details. Provider Contracts do not require application or written approval for pricing.

In contrast to the exception for Comparable Unaffiliated Sales, in most cases, an invoking of the general concept of "fair market value" or being "market priced" will not overrule the requirements regarding reporting Affiliate costs on the FSR at only the Affiliate's actual cost. Fair market value will only apply to goods or services that meet all the following criteria: 1) standardized, equivalent, easily measurable, and comparable; 2) bought and sold widely, by numerous unrelated third-party buyers and multiple unrelated third-party sellers; and 3) have a readily available independent source for comparative market pricing data. Similarly, "commercial item status" will only apply to items that are readily available to buyers off-the-shelf, with easily discernible prices. The above would require situations where there are directly comparable services that are provided and sold to multiple unaffiliated third parties, and wherein the price, terms, and details of service in these third-party transactions are readily apparent (or can be provided to HHSC's satisfaction).

If an MTO has Affiliate costs that it believes meet the criteria stated herein of either fair market value or commercial item status, it must receive HHSC's prior written consent prior to FSR submission. The burden is on the MTO to demonstrate to HHSC that the Affiliate costs meet the criteria. It is not the responsibility of HHSC or its auditor to develop a market comparison analysis or to independently verify in any other way that the criteria are met.

Conducting studies (by third-party experts or otherwise) to determine an "industry range" of a percentage of premiums to assess for corporate overhead and services, or being "within market standards" or "based on prevailing market terms" for pricing, etc., does not provide valid grounds to include in the FSR an Affiliate fee assessment in excess of the actual costs incurred by the Affiliate.

(4) Affiliate vs. unaffiliated third party Subcontracts. MTOs may contract with Affiliates for various services in order to take advantage of economies of scale, potentially superior capabilities, and for other possible advantages or reasons. If the MTO procures services outside of unaffiliated, true arm's-length situations, additional efforts by the MTO may be required to demonstrate allowability.

Amounts paid to affiliated Subcontractors for goods and services rendered may not be allowable for FSR reporting purposes if they do not fall under an allowable category. MTO costs that are unallowable in terms of FSR reporting may not become an allowable deduction against reported FSR profitability by virtue of routing those costs through an Affiliate.

(5) Administrative expense assessment "true-up." Affiliate administrative services Subcontracts (e.g., a Subcontract with the MTO's parent for headquarter support functions) must be limited to allowable costs incurred by the Affiliate. In many cases, these Subcontracts may be initially paid monthly, based on a pre-determined formula, such as a percentage of the MTO's revenues, a fixed per-member-per-month amount, or a flat monthly amount. When such a formula-based approach is used by an Affiliate, the MTO must do an end-of-year "true-up" of the actual allowable charges incurred by the Affiliate, versus the amounts initially recorded on the FSR by the formula. The MTO must modify the FSR accordingly to represent only allowable costs actually incurred by the Affiliate. Such a true-up must be done, and its impact included into the FSR, no later than the 120-day FSR for each SFY.

E. Managed Transportation owned-fleet and/or Affiliate fleet operating costs

Any MTOs operating owned-fleets for the provision of non-emergency medical transportation services under the Managed Transportation Program, as well as any MTOs contracting with an Affiliate for the provision of such services, are subject to the methodology described herein with respect to the manner in which such transportation operating costs may be included in the FSR.

"Owned-Fleet Transportation Operating Costs," as defined in the section below, are not allowable costs for inclusion in HHSC's FSR report. Instead of reporting costs on the FSR for gasoline, vehicle maintenance, driver wages, etc., the MTO must instead report per-trip fees (and/or any related per-unit-of-service fees), according to a pre-determined

written fee schedule or contract, just as it would for billing any unrelated party under contract for specific services provided.

II. Definitions

Advertising Costs means the costs of Advertising Media and corollary administrative costs, including the MTO's cost of events oriented specifically and narrowly at outreach to potential Medicaid Members in Texas.

Advertising Media means magazines, newspapers, radio and television programs, billboards, bus and bench displays, banners, telephone books, outreach brochures, outreach exhibits, posters, stickers, decals, and internet advertisements. Advertising Media also includes promotional items and memorabilia, such as low-cost-per-item giveaways, souvenirs, and models, if these items are distributed to Program-eligible individuals or their family members. In order to qualify as Advertising Media, the item in question must be designed or intended to be read, heard, or seen by Medicaid Members or potential members in Texas.

Allocable Cost means a cost that is allocable to the Contract if: (a) the goods or services involved are specifically chargeable or assignable to the Contract in accordance with relative benefits received, (b) all activities which benefit from MTO's indirect cost will receive an appropriate allocation of indirect costs, (c) any cost allocable to the Contract under the principles provided for in this document may not be charged to other contracts to overcome deficiencies, to avoid restrictions imposed by law or terms of such contracts, or for other reasons.

Allowable Expenses are defined in Contract Terms and Conditions. A designation of "allowable" or "unallowable" does not generally govern whether the MTO can incur a cost or make a payment; allowability only reflects what is reportable on the FSR. To be allowable, expenses must conform to the requirements of the Cost Principles, which include being reasonable and allocable.

Direct Costs means those costs that can be identified specifically with and are readily assignable to the objectives of this Contract. A particular type of cost may benefit one or more other activities of MTO, but a portion of such cost may be readily assignable to the Contract 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 Contract are generally categorized as direct costs. However, any direct cost of a minor amount may be treated as an indirect cost for reasons of practicality where the accounting treatment for such costs is consistently applied to all activities of the MTO.

Directly Associated Cost is defined in 48 CFR § 31.001.

Experience Rebate is defined in the Contract Terms and Conditions.

Indirect Costs means those incurred for a common or joint purpose benefiting the Contract and one or more other activities of the MTO and are not readily assignable to the activities specifically benefited, without effort disproportionate to the results

achieved. To facilitate equitable distribution of indirect expenses to the activities benefited, it may be necessary to establish a number of pools of indirect costs within the various departments of the MTO. 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 Contract, the MTO is not allowed to include any indirect costs which do not benefit the objectives under the Contract.

Marketing Expenses means certain marketing-related expenses that are:

1) allowable for inclusion in the FSR, and
2) are to be recorded on the Marketing line in the Administrative Expenses tab of the FSR.

Note that this is a more narrow definition than in the classic business sense. In this regard, Marketing Expenses are largely tied to outreach efforts, and do not include certain allowable related other costs, such as general public relations or advertising for recruitment of personnel. For more specific details, see "Marketing, Advertising, and Public Relations Costs" under Section VI, "Cost Categories."

Other Marketing Costs means any marketing costs that do not fall under the categories of Advertising Costs or Public Relations Costs.

Owned-Fleet Transportation Operating Costs means the direct costs of running and operating vehicles for the provision of non-emergency medical transportation services. This includes vehicles either owned, leased, or under the operating control of the MTO, or any Affiliate of the MTO. This also includes drivers and related personnel that are either on the payroll of, or under the operating control of, the MTO or any Affiliate of the MTO. Such direct costs include, but are not limited to, vehicle maintenance and repair; vehicle and related equipment depreciation; vehicle leasing or rental costs; related insurance; gasoline, oil, tires, parts, and supplies; salaries, wages, benefits, per trip fees, and any other compensation paid to drivers, mechanics, and fleet operations personnel; related space costs, including fleet operations garage or office building rent, lease, mortgage, interest, insurance, utilities, etc.; any fleet related taxes, regulatory fees, payroll processing fees, bookkeeping costs, legal fees, or professional services; fleet-related office supplies, telecom, internet and broadband costs; management overhead and/or assessments; and, any other costs or expenses that would normally pertain to the income statement of a fleet operations department or company.

Pre-implementation Costs means those costs incurred by the MTO on or after the Effective Date of the Contract but prior to the Operational Start Date of the Contract. Pre-implementation expenses are an allowable expense to Rate Period 1, subject to the limitations contained in Uniform Managed Care Contract Terms and Conditions, Article 10. Expenses must be reported for each month in which the expenses were incurred and must be reported separately in the Financial Statistical Report (FSR). These expenses must be counted toward the calculation of total expenses for the first FSR reporting period for the purposes of calculating the net income before taxes. These expenses must not be allocated or amortized beyond the first FSR reporting period.

Public Relations Costs means the MTO's costs of community relations and those activities dedicated to maintaining the image of the MTO, or maintaining or promoting understanding and favorable relations with the community, public at large, or any segment of the public. This includes MTO news releases and MTO press releases.

Reasonable Cost means a cost that, in its nature and amount, does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. In determining reasonableness of a given cost, consideration must be given to: (a) whether the cost is of a type generally recognized as ordinary and necessary for the operation of the MTO or the performance of the services required under the Contract, (b) the restraints or requirements imposed by such factors as: sound business practices; arms length bargaining; federal, state, and other laws and regulations; and, terms and conditions of the Contract, (c) market prices for comparable goods or services, (d) whether the individuals concerned acted with prudence in the circumstances considering their responsibilities to the MTO, its employees, the public at large, and the State of Texas, and (e) significant deviations from the established practices of the industry which may unjustifiably increase the cost incurred by the MTO to provide the services required under the Contract. To be allowable, "reasonable" costs still must meet requirements under the Cost Principles, especially with respect to Affiliate transactions.

III. Applicable Credits

Applicable credits refer to those receipts or reduction of expenditure-type transactions that offset or reduce expense items allocable to the Contract 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 MTO relate to allowable costs, they must be credited to this Contract either as a cost reduction or an increase in revenues, as appropriate.

IV. Composition of Administrative Costs

The total administrative expenses of the Contract are comprised of the allowable direct costs of the program, plus its allocable portion of allowable indirect costs, less applicable credits. There is no universal rule for classifying certain costs as either direct or indirect under every accounting system. A cost may be direct with respect to some specific service or function of the MTO but indirect with respect to the objectives under the Contract. Therefore, it is essential that each item of cost be treated consistently in like circumstances either as a direct or an indirect cost.

Fees based on profitability. Between affiliated entities, variable fees (or cost rates) that are dependent on the *level* of profitability are unallowable, except when HHSC grants a specific written exception, which will only be granted when it is in the best interest of HHSC or its constituents. Any MTO desiring an exception must submit a formal written request, demonstrating the reasonableness, the clear benefit to the program, the proposed methodology, and the financial implications.

V. Allocation of Indirect Costs

Unless specifically allowed by HHSC, indirect costs that are assessed or allocated by a parent company or affiliate to the relevant operating subsidiary are only allowable to the extent that: (a) the costs clearly represent specifically identified operating services provided for the operating subsidiary; and (b) the services directly benefit HHSC or its clients/customers (i.e., Medicaid Members).

These specifically identified and directly beneficial services would include core operating functions (e.g., centralized accounting, billing, IT), but would not include or allow items such as: vague management allocations where there is no clear and direct identifiable benefit to the contract, or fees that are assessed in addition to total (direct and indirect) costs, or overhead expenditure levels deemed clearly unreasonable (e.g., travel by private jet). During any audit verification or prospective contract review, expenditures must be broken out separately by function and meet the test of reasonability, and other requirements described in the Cost Principles.

The MTO must develop a written cost allocation methodology policy. The allocation methodology is subject to audit, and must allocate costs in an appropriate manner.

See also "Administrative expense assessment 'true-up'" and other portions of Section I(D).

VI. Cost Categories

1. Accounting. The cost of establishing and maintaining accounting and other information systems is allowable.
2. Add-on Fees. Amounts paid to an Affiliate that are in excess of actual costs incurred by the Affiliate, or that do not represent a pass-through of the actual costs of the Affiliate, are unallowable for cost-reporting on the FSR. This includes profit, margin, or mark-ups added to, or included in, Affiliate costs. Certain exceptions may apply; see Section I(D)(3), "Exceptions to Affiliate cost-based reporting."
3. Administrative Assessments. Certain parent company cost assessments for various administrative services provided to the MTO are allowable. However, any administrative services fees paid to, or assessed by, a parent or other Affiliate, which are unsupported in terms of actual documented specific allowable costs incurred by the Affiliate, are unallowable for cost-reporting on the FSR.
4. Advisory Councils. Costs incurred by advisory councils or committees are generally unallowable; any exceptions would require advance review by HHSC and would be subject to audit.
5. Alcoholic Beverages. Costs of alcoholic beverages are unallowable.
6. Audit Services. The costs of audits are allowable provided that the audits were performed in accordance with Generally Accepted Auditing Standards promulgated by the American Institute of Certified Public Accountants.

7. Automatic Electronic Data Processing. The cost of data processing services is allowable.

8. Bad Debts. Any losses arising from uncollectible accounts and other claims, and related costs, are unallowable.

9. Bonding Costs. Costs of bonding employees and officials are allowable to the extent that the bonding is in accordance with sound business practice.

10. 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.

11. Budgeting. Costs incurred for the development, preparation, presentation, and execution of budgets are allowable.

12. Capital expenditures. Expenditures for equipment or buildings, or repairs that materially increase the value or useful life of buildings or equipment, should be capitalized, and are unallowable, in terms of being totally expensed when initially incurred. Depreciation of these capital expenditures, and maintenance expenses, in accordance with Generally Accepted Accounting Principles (GAAP), OMB Circular A-122, or the Federal Acquisition Regulations (FAR), are allowable.

13. Communications. Costs of telephone, mail, messenger, and similar communication services are allowable.

14. 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 Contract, including wages, salaries, and fringe benefits. The costs of compensation are allowable to the extent that they satisfy the specific requirements of the Cost Principles, and that the total compensation for individual employees:

        1. Is reasonable for the services rendered and conforms to the established policy of the MTO consistently applied to all of its activities;

        2. Follows an appointment made in accordance with the MTO's policies and meets merit system or other requirements required by Federal law, where applicable; and

        3. Is determined and supported as provided in Section VI(14)(h).

    b. Reasonableness. Compensation for employees engaged in work on the Contract will be considered reasonable to the extent that it is consistent with that paid for similar work in other activities of the MTO. In cases where the kinds of employees required for the Contract are not found in the other activities of the MTO, compensation will be considered reasonable to the extent that it is comparable to that paid for similar work in the labor market in which the MTO competes for the kind of employees involved. Compensation surveys providing data representative of the labor market involved will be an acceptable basis for evaluating reasonableness.

c. Unallowable Costs. Costs that are unallowable under other sections of the Cost Principles will not be allowable under this section solely on the basis that they constitute personnel compensation.

d. Fringe benefits.

1. Fringe benefits are allowances and services provided by employers to their employees as compensation in addition to regular salaries and wages. Fringe benefits include the costs of leave, employee insurance, pensions, and unemployment benefit plans. Except as provided elsewhere in these principles, the costs of fringe benefits are allowable to the extent that the benefits are reasonable and are required by law, the MTO-employee agreement, or an established policy of the MTO.

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 MTO; and (c) the accrual basis of accounting utilized for costing each type of leave is consistently followed by the MTO.

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 MTO 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; employee life, health, unemployment, and worker's compensation insurance (except as indicated in Section VI(28), “Insurance and Indemnification”); pension plan costs (see Section VI(14)(e)); 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 Contract and all other activities of the MTO 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 Contract.

e. Pension Plan Costs. Pension plan costs may be computed using an acceptable actuarial cost method recognized by GAAP in accordance with established written policies of the MTO.

1. Pension costs calculated using an actuarial cost-based method are allowable for a given fiscal year if they are funded for that year within six months after the end of that year. Costs funded after the six-month period (or a later period agreed to by HHSC) are allowable in the year funded.

2. Amounts funded by the MTO in excess of the actuarially determined amount for a fiscal year may be used as the MTO's contribution in future periods.

3. The Contract must receive an equitable share of any previously allowed pension costs (including earnings thereon) which revert or inure to the MTO in the form of a refund, withdrawal, or other credit.

f. Post-Retirement Health Benefits. Post-retirement health benefits (PRHB) refers to costs of health insurance or health services not included in a pension plan covered by Section VI(14)(e) for retirees and their spouses, dependents, and survivors. PRHB costs may be computed using an acceptable actuarial cost method recognized by GAAP in accordance with established written polices of the unit.

1. PRHB costs calculated using an actuarial cost method recognized by GAAP are allowable if they are funded for that year within six months after the end of that year. Costs funded after the six-month period (or a later period agreed to by HHSC) are allowable in the year funded.
2. Amounts funded in excess of the actuarially determined amount for a fiscal year may be used as the MTO's contribution in a future period.
3. To be allowable in the current year, the PRHB costs must be paid either to:

   (a) The MTO or other benefit provider as current year costs or premiums, or

   (b) The MTO or trustee to maintain a trust fund or reserve for the sole purpose of providing post-retirement benefits to retirees and other beneficiaries.
4. The Contract must receive an equitable share of any amounts of previously allowed post-retirement benefit costs (including earnings thereon) that revert or inure to the MTO in the form of a refund, withdrawal, or other credit.

g. Severance Pay.

1. Payments in addition to regular salaries and wages made to rank-and-file workers whose employment is being terminated are allowable to the extent that, in each case, they are required by (a) law, (b) a group employer-employee agreement, or (c) established written policy.
2. Severance payments (but not accruals) associated with normal turnover are allowable. Such payments must be allocated to all applicable activities of the MTO as an indirect cost.
3. Executive severance, abnormal, or mass severance pay will be considered on a case-by-case basis and is generally unallowable; any exceptions would require advance review by HHSC and would be subject to audit.

h. Support of Salaries and Wages. These standards regarding time distribution are in addition to the standards for payroll documentation.

1. Charges to the Contract for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted practice of the unit and approved by a responsible official(s) of the MTO.

2. No further documentation is required for the salaries and wages of employees who work in a single indirect cost activity.

3. Where employees are expected to work solely on a single contract, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that contract for the 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.

4. Where employees work on multiple activities, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation that meets the standards in Section VI(14)(h)(5) 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 MTO.

5. Personnel activity reports or equivalent documentation must meet the following standards:

   (a) They must reflect an after-the-fact distribution of the actual activity of each employee,

   (b) They must account for the total activity, for which each employee is compensated,

   (c) They must be prepared at least monthly and must coincide with one or more pay periods, and

   (d) They must be signed by the employee.

   Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to the Contract but may be used for interim accounting purposes, provided that:

   (a) The MTO's system for establishing the estimates produces reasonable approximations of the activity actually performed; and

   (b) 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.

6. Substitute systems for allocating salaries and wages to the Contract may be used in place of activity reports. These systems are subject to advance review by HHSC and will be subject to audit.

i. Employee Bonuses or Incentive Payments.

1. Employee bonuses are allowable if they are:

   (a) Part of and in conformance with an existing plan that has been submitted at least nine months in advance to HHSC, and which is in compliance with any relevant specific terms of the Contract, such as those describing the criteria required for an employee bonus or incentive payment plan;

(b) Based on individual or group performance with respect to clearly-stated goals within a defined period (generally either the MTO's fiscal year, the MTO Parent's fiscal year, the calendar year, or the FSR reporting period); and

(c) Paid after the end of and within 90 days of the defined period, and is not contingent upon future services any recipient would provide.

2. Bonuses paid or payable to an Affiliate are unallowable.

15. 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. The term "contingency reserve" excludes self-insurance reserves (see Section VI(28)(d)), pension plan reserves (see Section VI(14)(e)), and post-retirement health and other benefit reserves (see Section VI(14)(f)) computed using acceptable actuarial cost methods.

16. Contributions and Donations. Contributions and donations, including cash, property, and services, regardless of the recipient, are unallowable.

17. Cost of capital. Expenses representing the cost of capital in any manner are unallowable.

18. Defense and Prosecution of criminal proceedings, civil proceedings, and claims are generally unallowable.

a. An exception exists for an MTO to identify, investigate, or pursue recoveries relating to suspected Fraud, Abuse, or Waste of providers or unaffiliated subcontractors providing services under the Texas Medicaid contracts, as well as to assist with the prosecution of suspected Fraud, Abuse, or Waste with these providers or unaffiliated subcontractors. This exception includes reasonable associated costs incurred in:

1. identifying, investigating, or pursuing Fraud, Waste, or Abuse under the Texas Medicaid contracts;

2. any related cooperation with or assistance provided to any state or federal agency; and

3. related defense costs that arise as a result of actions against providers and unaffiliated subcontractors.

Costs incurred under this exception do not have to result in actual recoveries in order to qualify.

b. An exception exists for reasonable legal costs related to subrogation, third party recoveries, and provider credentialing matters, which are allowable if these costs are incurred directly in the administration of the Contract with HHSC.

However, no exception extends to the payment by the MTO or any Affiliate of any fines, penalties, settlements, imposed court costs or attorney fees, sanctions, damages, interest, or related types of expenses.

Legal or related costs are not allowable for prosecution of claims against a state or the Federal government or other governmental body; or in connection with any criminal, civil, or administrative proceeding commenced by a state or Federal government or any other governmental body.

19. Depreciation and Amortization.

    a. Depreciation and amortization are a means of allocating the cost of fixed assets and intangible assets to periods benefiting from asset use, respectively. Depreciation for a particular class of assets (e.g., buildings, office equipment, computer equipment) and amortization for a particular class of assets (e.g. patents, leasehold improvements) charged to the Contract must be determined on the same basis used for the entity-wide financial statements.

    b. The computation of depreciation must be based on the acquisition cost of the assets involved. The value of an asset donated to the MTO by an unrelated third party must be its fair market value at the time of donation.

    c. Charges for depreciation and amortization must be supported by adequate property records, including the amount of depreciation and amortization taken each period.

    d. Charges for amortization of intangible assets are allowable only to the extent that they represent direct costs for the acquisition of proprietary processes (patents, copyrights, etc.) to be used exclusively in fulfilling the objectives of the Contract. Charges for amortization of intangible assets not related to proprietary processes, such as goodwill and debt acquisition costs, are unallowable.

20. Employee Health and Welfare Costs. The costs of health or first-aid clinics or infirmaries, employee counseling services, employee information publications, and any related expenses incurred in accordance with the MTO's policy are allowable. Income generated from any of these activities will be offset against expenses.

21. 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.

22. 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, are unallowable except when incurred as a result of compliance with specific provisions of the Contract or written instructions by HHSC authorizing such payments in advance.

23. Income taxes. Federal, state, and local taxes on income are unallowable. This includes excess profit taxes; corporate income taxes paid by a parent; and other income taxes paid by a parent or other Affiliate.

24. Investment Management Costs. Costs of investment counsel and staff and similar expenses incurred to enhance income from investments are unallowable.

25. Liquidated Damages paid to the Health and Human Services Commission, and any other similar fines, penalties, or settlement payments, are unallowable.

26. Losses on Disposition of Depreciable Property and other capital assets are unallowable.

27. Idle Facilities and Idle Capacity.

    a. As used in this Section the following terms have the meanings set forth below:

        1. 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 MTO.

        2. Idle facilities means completely unused facilities that are excess to the MTO's current needs.

        3. 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.

        4. 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 are unallowable.

28. Insurance and Indemnification.

    a. Costs of insurance that is required and maintained pursuant to the Contract are allowable but subject to audit.

    b. Costs of other insurance in connection with the general conduct of activities are allowable if the types, extent, and cost of coverage are in accordance with the MTO's policy and sound business practice.

    c. Actual losses that could have been covered by permissible insurance (through a self-insurance program or otherwise) are unallowable, unless expressly provided for in the Contract or as described below. Costs incurred because of losses not covered under nominal deductible insurance coverage provided in keeping with sound management practice, and minor losses not covered by insurance, such as spoilage, breakage, and disappearance of small hand tools which occur in the ordinary course of operations, are allowable.

    d. Contributions to a reserve for certain self-insurance programs including workers' compensation, unemployment compensation, and severance pay are allowable subject to the following provisions.

        1. The type of coverage, the extent of coverage, and the rates and premiums would have been allowed had insurance (including reinsurance) been purchased to cover the risks. However, provision for known or reasonably estimated self-insured liabilities, which do not become payable for more than

one year after the provision is made, must not exceed the discounted present value of the liability. The rate used for discounting the liability must be determined by giving consideration to such factors as the settlement rate for those liabilities and its investment rate of return.

2. Earnings or investment income on reserves must be credited to those reserves.

3. Contributions to reserves must be based on sound actuarial principles using historical experience and reasonable assumptions. Reserve levels must be analyzed and updated at least biennially for each major risk being insured and take into account any reinsurance, coinsurance, etc. Reserve levels related to employee-related coverage will normally be limited to the value of claims (a) submitted and adjudicated but not paid, (b) submitted but not adjudicated, and (c) incurred but not submitted. Reserve levels in excess of the amounts based on the above must be identified and justified in the cost allocation plan or indirect cost rate proposal.

4. Accounting records, actuarial studies, and cost allocations (or billings) must recognize any significant differences due to types of insured risk and losses generated by the various insured activities or agencies of the governmental unit. If the MTO experiences significantly different levels of claims for a particular risk, those differences are to be recognized by the use of separate allocations or other techniques resulting in an equitable allocation.

5. Whenever funds are transferred from a self-insurance reserve to other accounts (e.g., general fund), refunds must be made to HHSC for its share of funds transferred, including earned or imputed interest from the date of transfer.

e. Actual claims paid to or on behalf of employees or former employees for workers' compensation, unemployment compensation, severance pay, and similar employee benefits (e.g., post retirement health benefits), are allowable in the year of payment provided (1) the MTO follows a consistent costing policy, and (2) they are allocated as a general administrative expense to all activities of the MTO.

f. Insurance refunds must be credited against insurance costs in the year the refund is received.

g. Indemnification includes securing the MTO against liabilities to third persons and other losses not compensated by insurance or otherwise. HHSC is obligated to indemnify the MTO only to the extent expressly provided for in the Contract.

29. Interest. In general, interest expense is unallowable. This includes interest expense incurred by a parent or other Affiliate. Costs incurred for interest on borrowed capital or the use of the MTO's own funds, however represented, are unallowable, except as provided in Section VI(41)(d) (regarding rental costs for certain leases).

30. Lobbying. The cost of activities associated directly or indirectly with influencing local state or federal legislation is an unallowable cost.

31. 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 to the extent that they: (1) keep property in an efficient operating condition, (2) do not add to the permanent value of property or appreciably prolong its intended life, and (3) are not otherwise included in rental or other charges for space. Costs that add to the permanent value of property or appreciably prolong its intended life must be treated as capital expenditures.

32. Marketing, Advertising, and Public Relations Costs.

a. Applicability

This Section describes the advertising, marketing, promotional, outreach, and public relations activities (collectively "marketing activities") that an MTO is permitted to *record as an allowable expense* on the FSRs. For rules concerning *permissible* marketing activities, refer to the Contract's section on Marketing Policies and Procedures. A marketing activity may be permissible under the Contract's section on Marketing Policies and Procedures, but not an allowable expense for purposes of FSR reporting. A communication from HHSC regarding specific permitted marketing practices does not override language in this Section regarding the allowability of expenses.

This section describes the costs allowable for inclusion on the FSR, and the specific line items for recording those costs on the FSR.

b. Costs That Are Allowable as Marketing Expenses on the FSR

The following costs are allowable as deductible expenses on the FSR, subject to the limitations as listed under Section VI(32)(d), "Unallowable Costs". MTO should record the following costs on the Marketing Expenses line item on the FSR.

1. Advertising Costs, when incurred by the MTO for promotional and outreach efforts, if all three of the following criteria are met:

(i) an HHSC Program that the MTO participates in is mentioned within the promotional or outreach materials;

(ii) the advertising (or related activity) is not in violation of the Contract's section on Marketing Policies and Procedures; and

(iii) the primary target audience consists of Medicaid or Program eligibles in Texas.

2. Other Marketing Costs, when incurred by the MTO for the following items:

(i) member surveys;

(ii) member focus groups and advisory committees;

(iii) materials or events oriented specifically at member education or community health education;

(iv) certain Marketing Incentives (of such Incentives are defined and allowed in the Contract);

(v) non-cash promotional items and giveaways valued at $10 or less each, that are distributed solely to current or prospective Texas Medicaid Members or their families; or

(vi) reasonable payments for booth rentals at events attended by the MTO for member outreach purposes, which events are attended by prospective Texas Medicaid Members or their families.

c. Related Costs That Are Allowable on the FSR, But Not as Marketing Expenses

The following costs are allowable as deductible expenses on the FSR, subject to the limitations as listed under Section VI(32)(d), "Unallowable Costs," but should NOT be recorded on the Marketing Expenses line item on the FSR.

1. Provider directories, provider manuals, and member handbooks. These items are not considered to be Marketing Expenses for FSR reporting purposes. Costs associated with directories, manuals, and handbooks should be recorded under Printing or Postage, as may be appropriate. If an external firm handles some of this effort, the Outsourced Services line item may be utilized for the appropriate portion of those costs. Any allowable related costs that do not fit under these line items should be recorded under Other Administrative Services.

2. Mailing and printing costs for correspondence with current members. These items are not considered Marketing Expenses, unless a specific effort is primarily oriented towards member retention or member renewal. Allowable costs associated with these items should be recorded in the same manner described above for directories, provider manuals, and handbooks.

3. Certain non-marketing Advertising Costs, when incurred by the MTO for:

(i) the recruitment of personnel to perform services for the HHSC Program(s);

(ii) the procurement of goods and services for the HHSC Program(s);

(iii) the disposal of surplus materials directly by the MTO; or

(iv) certain limited other cases, where the incurrence of Advertising Costs are necessary to meet the requirements of the Contract with HHSC.

These non-marketing Advertising costs should be recorded as Other Administrative Expenses.

4. Public Relations Costs incurred by the MTO as a direct, non-allocated cost for public relations activities are allowable in the following circumstances:

(i) public relations activities required by the Contract with HHSC;

(ii) costs incurred to communicate with the public and press pertaining to specific activities, accomplishments, or outcomes that result from

performance of services under the Contract with HHSC, as long as the MTO includes the name of the applicable HHSC Program(s);

(iii) costs related to the Contract with HHSC that are incurred to:

(A) respond to inquiries on the MTO's policies and activities;

(B) communicate with the public and press; or

(C) conduct general communication with news media, to the extent that the activities are limited to communication necessary to keep the public informed on matters of public concern such as notice of contract awards, facility closings or openings, employee layoffs or rehires, financial information; and

(iv) costs of MTO participation in community service activities (e.g., blood bank drives, charity drives, disaster assistance).

Valid Public Relations costs should be recorded in the FSR on appropriate line items similar to as described under website hosting costs in this Section.

5. Basic website costs, including home-site hosting, site maintenance, etc. These items are not considered Marketing Expenses, unless the cost is dedicated to the procurement of internet advertising. Hosting and maintenance should be recorded under Salaries for that portion that represents in-house efforts, to Outsourced Services for appropriate external fees, and otherwise to Other Administrative Expenses.

6. Marketing-related and Public Relations related overhead allocations (or assessments), from a parent (or other Affiliate). Such allocations and assessments generally should be recorded under Affiliate Company Allocations/Charges. An exception to this would be for a cost that solely represents a direct net payment to an unaffiliated third party, wherein the payment is specifically for advertising directed to Program-eligible populations in Texas, in which an HHSC Program is mentioned.

7. Costs of professional and industry organizations, associations, and periodicals, including memberships, subscriptions, meeting costs, and associated dues, fees, contributions, reimbursements, etc. Valid costs associated with these professional association items should be recorded under Other Administrative Expenses.

8. Other related marketing and advertising type costs that are allowable per the Contract's section on Marketing Policies and Procedures, but excluded from being reported on the Marketing Expense line, should be reported on the FSR under Other Administrative Expenses if the MTO determines that no other line item is appropriate.

d. Unallowable Costs

Advertising Costs, Public Relations Costs, and Other Marketing Costs that are not allowable expenses on the FSR include the following.

1. Any media or efforts that do not mention the MTP Program. An exception to

this is non-cash promotional items and giveaways valued at $10 or less each, which are distributed solely to current or prospective Texas Medicaid Members or their families.

2. Any activity that does not comply with the Contract's section on Marketing Policies and Procedures.
3. Any costs associated with any of the following:
   (i) any written or oral statements containing material misrepresentations of fact or law, or that are in any manner determined by HHSC to be significantly misleading;
   (ii) usage of "Spam," as defined by the Contract's section on Marketing Policies and Procedures;
   (iii) materials used or efforts directed, in whole or in part, at anything unrelated to the applicable HHSC Program;
   (iv) activities outside the State of Texas;
   (v) royalty fees or franchise fees;
   (vi) gifts or gratuities (excluding certain low-cost-per-item mass-produced promotional giveaway items, as may be allowed under the requirements of Section VI(32)(b)(2));
   (vii) charitable donations of any kind, including cash contributions to non-profit organizations, and paid sponsorships;
   (viii) Value-Added Services;
   (ix) the costs of conventions, retreats, gatherings, parties, awards presentations, appreciation events, celebrations, entertainment, non-outreach activities, internal meetings, or events related to internal activities of the MTO or its Affiliates;
   (x) expenses related to events described in Section VI(32)(d)(3)(ix) above, including costs associated with displays, demonstrations, and exhibits; costs of meeting rooms and hospitality suites; and any related airfare, lodging, meals, car rental, fuel, taxi, mileage, parking, laundry, entertainment, and other travel expenses;
   (xi) unsolicited direct mail to non-members; cold-calling; door-to-door marketing; or acquisition or development of non-member mailing lists;
   (xii) fees (including assessments, allocations, overhead, or other charges) invoiced from a parent organization (or other Affiliate), for any advertising related costs, public relations related costs, or other marketing expenses. An exception to this would be where any costs pertain directly and solely to an HHSC Program, and represent only the direct net external payment to an unaffiliated third party.
4. Costs of memberships in civic or community organizations, including dues and expenses associated with country club and fraternal organizations.

5. Political contributions or costs associated with lobbying, and any costs associated with elected officials or candidates.

6. Any costs or activities that do not comply with OMB Circular A-122 or the Federal Acquisition Regulations (FAR), including 42 C.F.R. § 438.104.

33. Materials and Supplies. The cost of materials and supplies is allowable. Purchases should be charged at their actual prices after deducting all cash discounts, trade discounts, rebates, and allowances received. Withdrawals from general stores or stockrooms should be charged at cost under any recognized method of pricing, consistently applied. Incoming transportation charges are a proper part of materials and supply costs.

34. Memberships, Subscriptions, and Professional Activities.

    a. Costs of the MTO's memberships in business, technical, and professional organizations are allowable.

    b. Costs of the MTO'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 Section VI(47), "Travel Costs."

    d. Costs of membership in civic and community social organizations are unallowable.

    e. Costs of membership in organizations substantially engaged in lobbying are unallowable.

35. Motor Pools. The costs of a service organization that provides automobiles to the MTO at a mileage or fixed rate or provides vehicle maintenance, inspection, and repair services are allowable.

36. Pre-implementation Costs. Pre-implementation costs are certain costs incurred between the date of tentative Contract award, and the Effective Date of the Contract. Pre-implementation costs are allowable if such costs are included in a separate Implementation FSR submission (which is submitted within HHSC's timelines), and meet all of the following criteria.

    a. The costs are Reasonable Costs and would otherwise be allowable (if they had been incurred on or after the Effective Date) under the provisions of the Contract, and are necessary for the MTO to implement the Contract.

    b. The costs are Direct Costs under the provisions of the Contract.

    c. The costs are incremental. A cost is incremental if it would not have been incurred by the MTO in the absence of the Contract. For example, allocations of compensation costs for individuals who were employed by the MTO prior to or commensurate with the Effective Date of the Contract are reimbursable only if:

(1) the MTO can demonstrate that the employees were hired solely to provide services under the Contract, or received additional compensation (such as overtime) for services directly related to implementation of the Contract, or

(2) the MTO can support that the employees did work on Contract issues evidenced by supporting documentation such as time and attendance sheets or monthly work analysis worksheets.

Any allocated expenses (such as postage, office supplies, telephone, utilities, and printing) must be supported by an allocation methodology and documentation that the expense was necessary for Contract implementation. Costs associated with developing the RFP proposal response are not considered to be Pre-implementation Costs, and are unallowable.

d. If costs are paid or payable, directly or indirectly, to an Affiliate, supporting documentation must reflect that the MTO has not included on the FSR reporting any amounts paid to Affiliates for goods and services that would be deemed unallowable expenditures under the Contract (if they had been incurred on or after the Effective Date). See Section I(D), "Affiliate transactions and Affiliate cost reporting."

   Pre-implementation costs require submission of a specified spreadsheet and other documentation as may be prescribed by HHSC or its auditor. There are certain limitations for these costs in terms of the potential carry-forward of any Rate Period 1 losses.

   Costs incurred prior to the notification of Contract award, which may be incurred in anticipation of the award of the Contract, or in connection with Contract negotiations, bid preparation, or RFP submission, etc., are unallowable.

37. Professional Service Costs.

   a. 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 MTO, are allowable if they: are reasonable in relation to the services rendered; are not contingent upon recovery of the costs from HHSC; and do not conflict with any other provisions of the Cost Principles.

   b. Retainer fees supported by evidence of bona fide services available or rendered are allowable.

38. Proposal Costs. Costs of preparing proposals for potential contracts are unallowable.

39. 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.

40. Rebates and profit sharing. Unless specifically allowed by the HHSC contract, 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 contract, such that the fee is effectively a form of profit payment or rebate to the Affiliate, are unallowable unless specifically allowed by the HHSC contract.

41. Rental Costs.

    a. Subject to the limitations described in Sections VI(41)(b) through (41)(d), rental costs are allowable to the extent that the rates are reasonable when considering: rental costs of comparable property, if any; market conditions in the area; alternatives available; and the type, life expectancy, condition, and value of the property leased.

    b. Rental costs under sale and leaseback arrangements are allowable only up to the amount that would be allowed had the MTO continued to own the property.

    c. Rental costs under less-than-arms-length leases are allowable only up to the amount that would be allowed had title to the property vested in the MTO. For this purpose, less-than-arms-length leases include those where:

        1. One party to the lease is able to control or substantially influence the actions of the other;

        2. Both parties are parts of the same MTO, share the same parent, or are otherwise Affiliates; or

        3. The MTO creates an authority or similar entity to acquire and lease the facilities to the MTO and other parties.

    d. Rental costs under leases required to be treated as capital leases under GAAP, are allowable only up to the amount that would be allowed had the MTO purchased the property on the date the lease agreement was executed. This amount would include expenses such as depreciation, interest, maintenance, and insurance. The provisions of Financial Accounting Standards Board Statement 13 must be used to determine whether a lease is a capital lease.

42. Retrocession Agreements. "Retrocession" refers to a transaction where a reinsurer cedes or transfers back to the insured or its designee all or part of the reinsurance that the reinsurer previously assumed. While the reinsurer is "providing" ongoing reinsurance to the insured in one contract, it is simultaneously relieving itself of all or part of that reinsurance obligation in another contract. In conjunction with this transfer of risk away from the reinsurer, a retrocession agreement may involve the return of reinsurance premiums back to the insured or its designee, or the remitting of other payments from the reinsurer to the insured or its designee, that have the effect of substantially offsetting or reducing the gross amount that had been paid to the reinsurer by the insured in the original reinsurance.

    Any retrocession agreement that would impact FSR reporting and that fails to strictly meet the requirements of the Cost Principles prior to audit may be deemed a material breach of the Contract. A retrocession agreement may be permissible under the Contract only if it meets all the criteria listed in this section.

Any retrocession payments made by a reinsurer or its Affiliate that are related in any manner to the costs incurred or services performed under the MTO Contract, and which payments are or may be received by an MTO or an Affiliate, must be included in the FSR as a "contra-cost," or an offset to other reported costs, thus reducing overall expenses reported. Any retrocession payments that are contractually required due to activity in a given State Fiscal Year (SFY) must be reported in that SFY's FSR reporting, even if the payments are not received until a subsequent SFY. Retrocession agreements may not be utilized to shift FSR-reported profitability either between years or out of the MTO.

Copies of all retrocession agreements relating to the MTO Contract, including any amendments or renewals, must be sent to HHSC in advance of any usage which could be deemed to impact cost reporting on the FSR. Retrocession agreements, amendments, and renewals must receive HHSC's prior written approval and are subject to audit.

The above requirements (including the requirement to send copies in advance to HHSC) also apply to:

- any retrocession agreement (or payment) between an Affiliate and a third party, if the agreement (or payment) would affect the reported cost on the FSR; and,
- any "interests and liabilities contract" associated with any reinsurance agreement; "excess of loss reinsurance binder;" reinsurance-related "experience refunds;" and other arrangements that may affect similar mechanisms; and,
- any agreement or arrangement with a third party that wholly or partially negates, or significantly offsets, any reinsurance with the third party or any of its affiliates.

43. Risk Mitigation. Risk mitigation refers to the shifting of financial risk to another entity, in exchange for a payment. For purposes of FSR reporting, a reinsurance arrangement will be considered to have accomplished "risk mitigation" only to the extent that the arrangement shifts risk to a non-Affiliate. Further, retrocession arrangements may have the effect of cancelling all or part of the risk mitigation. Reinsurance is only an allowable cost to the extent that it accomplishes Risk Mitigation. Certain types of "reinsurance" that are utilized primarily as a financing mechanism may not be deemed by HHSC to accomplish Risk Mitigation, or the cost may be deemed to only partially pertain to Risk Mitigation.

44. Royalty Agreements (including associated fees, payments, expenses, and premiums). Payments to an Affiliate for any form of royalty are unallowable. This includes fees, payments, expenses, premiums, assessments, and overhead allocations to recognize the advantage or value of proprietary systems, business products, processes, and methodologies; intellectual property; brand name recognition; logos; experience and expertise; and ability to raise capital. Costs for these items are unallowable, regardless of whether they are labeled as royalty payments.

45. Taxes.

a. Income taxes and state franchise taxes are unallowable. In general, other taxes that the MTO is legally required to pay are allowable.

b. Gasoline taxes, motor vehicle fees, and other taxes that are in effect user fees for benefits provided to the federal government are allowable.

c. Any applicable Premium and Maintenance taxes are an allowable charge to the Contract.

d. This provision does not restrict HHSC's authority to identify taxes where state participation is inappropriate. Where the identification of the amount of unallowable taxes would require an inordinate amount of effort, HHSC may accept a reasonable approximation of the unallowable amount.

46. Training. The cost of training provided for employee development is allowable.

47. Employee Travel costs.

a. General. Travel costs for the MTO's employees 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 program. 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 MTO.

b. Lodging and subsistence. Costs incurred by employees and officers for travel, including costs of lodging, other subsistence, and incidental expenses, will be considered reasonable and allowable only to the extent the costs do not exceed charges normally allowed by the MTO in its regular operations as a result of the MTO's policy. 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.

d. Air travel by other than commercial carrier. Cost of travel by the MTO-owned, -leased, or -chartered aircraft, as used in this Section, includes the cost of lease, charter, operation (including personnel costs), maintenance, depreciation, interest, insurance, and other related costs. Costs of travel via the MTO-owned, -leased, or -chartered aircraft are unallowable to the extent they exceed the cost of allowable commercial air travel, as provided for in Section VI(47)(c).

VII. Other Costs

Failure to mention a particular item of cost in this document is not intended to imply that it is either allowable or unallowable; rather, determination of allowability in each case should be based on the treatment or standards provided for similar or related items of

cost. To be allowable as expenses under the Contract, costs must meet the following general criteria:

a. Be a reasonable cost under the provisions of the Contract and be necessary for proper and efficient performance and administration of the Contract.

b. Be an allocable cost under the provisions of the Contract.

c. Be authorized or not prohibited under state or local laws or regulations.

d. Conform to any limitations or exclusions set forth in these principles, terms and conditions of the Contract, laws, or other governing regulations as to types or amounts of cost items.

e. Be consistent with policies, regulations, and procedures that apply uniformly to both the Contract and other activities of the MTO.

f. Be accorded consistent treatment. A cost may not be assigned to the Contract as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Contract as an indirect cost.

g. Except as otherwise provided for in the Contract, be determined in accordance with Generally Accepted Accounting Principles.

h. Not be included as a reimbursable cost or used to meet cost sharing requirements of any other activity of the MTO during the Contract period.

i. Be net of all applicable credits.

j. Be adequately documented.

k. Affiliate costs must meet the same allowability requirements as those for the MTO. Other than the exceptions described in Section I(D), Affiliate costs must represent a pass-through of actual costs incurred by the Affiliate, with no mark-up.

Any legal commitments to make any payments to other parties (or any actual payments made to other parties) do not overrule the requirements described in the Cost Principles.

HHSC Financial Statistical Report (FSR) for the Medical Transportation Program

Quick Start instructional overview

This overview is primarily meant for first-time users of HHSC's FSR financial reporting templates. A more detailed and comprehensive set of instructions will be provided separately. In the event of any contradictions between that set of FSR Instructions and this overview, that set of instructions shall prevail. *Note that a number of tabs in this FSR do not require any input from the MTO.*

All entities under contract with HHSC for capitated full-risk programs, including all Managed Transportation Organizations and Full Risk Brokers, are required to submit FSRs to HHSC. FSRs are submitted Quarterly and after year-end, and financial penalties may be assessed for late, incomplete, or improper reporting. Substantial interest and/or penalties may be incurred by the MTO for mis-reporting.

Step 1. **File naming convention.**

Save a separate copy of the FSR template for each submission. Before you input anything, rename and save the MS Excel file in a format similar to this:

FSR - MTP - Region # - SFY#, Qtr#.xlsx

Example: FSR - MTP - Region 01 - SFY15, Qtr1.xlsx

If any contractor has more than one Region, then a separate report, and thus a separate spreadsheet file, must be submitted for each Region. If you submit a revised report, add REVISED to the end of the file name.

Step 2. **Organizational name, Region, timing.**

Go to the green tab labeled "1 Capitation pmts". In the first row, input your organization's legal name by selecting it from the drop down menu. In the second row, do likewise for your Region. In the third row, select the State Fiscal Year, and the Quarter, for which you are reporting. For example, under the State Fiscal Year (SFY), the first Quarter is always Sept 1st through Nov 30th. In the next two rows, input the date which you submit the report to HHSC, and the date through which the last services under this report were rendered (usually the last calendar day of the state fiscal Quarter). Once you have done the items above, they will be copied to all other tabs in the report.

Step 3. **Number of beneficiaries**

On the same tab, enter on spreadsheet row 12 (FSR form Line Item #7) the number of Adult beneficiaries in your Region for the first month under the appropriate monthly column, and also the number of beneficiaries for any other months in that reporting Quarter. The number will be reported to you by HHSC in the enrollment files you receive. The number generally varies somewhat from month to month. Row 12 is specifically for beneficiaries classified by HHSC as being in the "Adults" risk group, and who are also living in a county that has been designated as urban by HHSC. If your Region is entirely designated as rural counties, you would put zero in the urban line.

Step 4. **Payment amount from HHSC, per beneficiary, per month**

On the next row, in the first column, enter the official monthly capitation payment per member per month that has been set by HHSC for this risk group. Enter it in the September column even if you had no business under this contract during Sept. This rate usually stays the same for the entire SFY for each risk group. There may or may not be different rates for urban vs. rural.

Step 5. **Calculating total aggregate revenues from HHSC for the period**

Continue as above for all risk groups and months under this report. Note that in the far right-hand column, you will find the year-to-date amount (for the SFY) for each line item, and down below you will see the totals for the various line items combined. Note that certain cells in the spreadsheet are protected (for example, where there are forumlas to add totals, etc.).

You are only to input data in the unprotected cells, which are generally the tan-shaded cells which are empty. When you input something into these cells, the input data usually shows as blue font.

Protected cells generally show as black font; they are often unshaded, and sometimes shaded with gray for visual emphasis. Also note that the FSR Line Item numbers in spreadsheet column A are **bold red** for rows which require data input, and are black for rows which do not require input.

Step 6. **Direct Client Services Costs**

Operating costs for services provided to beneficiares will be entered in the yellow tabs (beginning with "2a Adults Urban"), labeled as 2a through 2f; each tab corresponds to a single risk group (as shown under the green "1 Capitation pmts" tab). If all counties in your Region are classified as rural counties by HHSC, you will only use the tabs marked Rural (tabs 2b, 2d, and 2f). Other Regions may use all the yellow tabs. Costs entered in the yellow tabs do *not* include any administrative overhead costs (eg, no costs for call centers, etc); those costs go in another tab.

All costs entered in the yellow tabs are aggregate *per-service* costs. No salaries, facility costs, etc., are entered here. The amounts paid by the MTO for beneficiary meals, along with the quantity of meals, are entered here; likewise for lodging, mass transit bus, and airline. It is no different for demand response. Each demand response trip has a charged cost attributable to that specific trip, and each of those trip costs, along with the corresponding number of trips and distance in miles, is entered.

If your organization utilizes any owned transportation, the specific trip charges assessed for any rides provided by owned transportation and/or employed drivers must be entered in the "Demand Response - Affiliate" row. Normal unaffiliated third-party purchased transportation is entered in the "Demand Response - Non-affiliate" row. HHSC will implement limits for the amount that can be charged for Affiliate demand response trips. In no case will driver wages, vehicle maintenace costs, gas, depreciation, etc., be entered anywhere in this report. Costs for any Affiliate transportation must be entred in terms of *per-trip* fees, along with the corresponding number of trips and the distance in miles.

Step 7. **Administrative Overhead Costs**

Costs for administrating the program are entered in the three orange tabs, tabs 3a through 3c (beginning with "3a Admin - Unaffil"). Note that *no* transportation-related costs are to be input in the Admin cost tabs.

Admin costs are divided between those paid directly by the legal entity that contracts with HHSC, vs. those that may be assessed to the MTO by the MTO's parent or other Affiliate. The first two tabs in this section, 4a and 4b, reflect this split. For example, a staff member whose W2 reflects the "employer" as being the same legal entity that holds the contract with HHSC (ie, the MTO), would be shown in the "Payments to unaffiliated parties" section, while a staff member whose W2 shows the parent's name (or the name of another Affiliate) would be shown under the "payments to Affiliated parties" section (since the MTO will have to in turn pay the parent or other Affiliate for these salaries). Likewise for rent, professional services fees, etc. If the MTO itself directly cuts a check to every employee and entity paid, and there are no payments to, or corporate assessments of any kind from, a parent or other Affiliate, then all of the MTOs admin would go in the "payments to unaffiliated parties" area. Be sure to refer to HHSC's Cost Principles for specific rules on allowable costs for inclusion in this FSR.

The third tab in this section, 4c, is a breakdown of the combined total salaries (incl benefits) by functional area (eg, how much is for operating an internal call center, vs. for accounting, etc.).

Step 8. **Total Summary Income Statement**

The next tab, in red, labled "4 Summary Inc Stmt," brings together data from the prior tabs, and shows the net income before taxes (as defined by HHSC) attributable to this Region under the contract with HHSC for this time period. There is very little input on this tab, but there are a few items, including any interest income earned off the float from the HHSC capitation pre-payments, and down at the bottom, any Liquidated Damages fines paid to HHSC by the MTO.

Step 9. **Sign-off for data certification**

The next tab, also in red, labled "5 Certification," is a required sign-off that the data is accurate and done in accordance with HHSC's contract rules (primarily The Cost Principles). This must be signed by the MTO's CEO or CFO, or the person holding the equivalent title within the MTO (ie, the MTO's top executive officer, or top financial officer). This sign-off cannot be delegated down. The MTO should print this tab, manually sign it, scan the signed original into a pdf file, and send the pdf to HHSC along with the FSR xls file. Be sure to update the "Submission Date" on row 4 in the "1 Capitation pmts" tab before saving the xls file for submission to HHSC.

Step 10. **Review of other summary data (optional)**

No tabs past the "5 Certification" tab require any input from the MTO. The tab labeled "scratch sheet" is entirely unprotected, and may be used by the MTO for any purpose, if desired. For example, you may have certain financial data that is generated by your internal system that comes in a certain format; you could do a data dump in your own format on this tab, and then reference cells in the tab by formula in other tabs, which could save time in filling in the form for subsequent submissions.

The "6 Doc History Log" will show descriptions of changes in subsequent versions of the spreadsheet. The remaining tabs, labeled 7a through 7d, show various data summaries generated by the data input in prior tabs. HHSC utilizes these tabs for analysis, and the MTO may find this useful, as well.

Attachment L – MTP Financial Statistical Report

See Procurement Library

Attachment M –MTO DISCLOSURE STATEMENT

Applicability of this document

This statement is to be completed by each Managed Transportation Organization (MTO) that contracts with HHSC to provide Medical Transportation Program (MTP) services in Texas. If an MTO contracts with HHSC under more than one legal name, then the MTO should complete a separate statement for each such legal entity. The statement discloses information about the MTO, including ownership, type of entity, Affiliates (as defined in the Contract), and other related parties. The statement also discloses transactions with such parties, subcontracts, provider fraud, solvency, any criminal convictions, etc.

The statement must be submitted before: 1) beginning operations under a new contract; 2) by September 1st annually thereafter; and, 3) as changes occur in the MTO's status or responses (via an abbreviated change notification version – UMCM Chapter 5.3.2.1).

Note that HHSC's request for information regarding the existence of possible transactions, arrangements, relationships, etc., does not confer or imply allowability or unallowability of the issue under inquiry. Unless otherwise instructed, the signed statement should be submitted to HHSC as a PDF file, showing written signature. Please fill-in the date this form is submitted in the designated space at the top of Page 1 of the form.

Per Federal regulations: *A Medicaid agency shall not approve a contract, and must terminate an existing contract, if certain contractors fail to disclose certain ownership and control information* (42 CFR 455.104).

MTOs should complete the following sections, and attach all exhibits following Section H:

Section: Page

*DATE SUBMITTED:*_____

A. MTO identification and ownership.

1. Full legal name of the MTO that contracts with HHSC:

2. Other names. Doing business as (DBA), trade name(s), abbreviation, nickname, acronym, former name(s), etc. (list any and all, if different from legal name):

3. Primary street (physical) address of MTO, including zip code, area code and main phone number:

4. Primary mailing address of MTO, if different from physical address (if not different, so state):

5. Website address(es) (list any and all home-page URLs):

6. a. State of incorporation of MTO: _____

   b. MTO's Employer Identification Number (EIN): _____

7. a. Legal status of MTO: ☐ For-Profit ☐ Non-Profit

   b. Legal status of Ultimate Owner (as named in Item 15 below): ☐ For-Profit ☐ Non-Profit

8. Top Officer/Executive. Name, title, and location of the top officer or executive of the MTO:

9. Primary Contact. Indicate MTO's present designated primary contact for HHSC. Include name, title, email address, phone #, mailing address, fax #, office location, and the name and title of the person to whom the primary contact reports.

10. Senior Executives and Top Management, etc.

    a. Provide full names (with full titles) of any and all persons presently holding title(s) of (or similar to):

    - Chairman, CEO, President, COO, (E)VP-Operations, Executive Director, Managing Director, General Manager, Chief Administrative Officer, Partner; and,

(continued on next page)

- CFO, (E)VP-Finance, Chief Accounting Officer, Controller, Director of Finance and/or Accounting, Finance Manager, Accounting Manager, Treasurer, Financial Functions Manager; and,
- Medical Director, Chief Medical Officer.

Include and indicate the top financial person. Include all executives who sign contracts on behalf of the MTO with HHSC, and those who sign tax returns or regulatory filings, and indicate these on list. Include all officers of the corporation.

Also include other employees, if any, that have employment agreements that provide for any annual compensation in excess of $250,000, including the potential value of contingent (e.g., performance) pay, bonuses, options, allowances, etc., severance pay for change in control, and, any benefits in excess of that provided to most salaried employees. Include anyone not already indicated above who is one of the five highest paid employees in the MTO.

Include any Board of Directors member or 5+% owner, if such individual has either a company salary or a consulting agreement, which (separately or combined) is in excess of $125,000 per year, including the value of any bonuses, options, allowances, etc.

Provide titles for everyone in the list, and indicate which of the criteria above places them on the list. Use an additional page if needed.

Note: It is not necessary to disclose the total amount of the compensation package(s); but only whether they meet the disclosure threshold.

b. Indicate if any person named in (a) above:

i. has a 5% or more ownership interest (directly, or indirectly through one or more intermediaries) in any of the MTO's subcontractors, network providers, or in any other MTO:

☐ Yes. ☐ No. If yes, provide name(s):

ii. is related as spouse, parent, child or sibling to any person with a 5% or more ownership in any of the MTO's providers or in any other MTO:

☐ Yes. ☐ No. If yes, provide name(s):

iii. is a corporate officer, Board of Directors member, partner, senior executive, or is in any manner part of top management, or holds an employment contract or consulting agreement, with any of the MTO's providers or in any other MTO:

☐ Yes. ☐ No. If yes, provide name(s):

(continued on next page)

iv. is related as spouse, parent, child or sibling to any person who is a corporate officer, Board of Directors member, partner, senior executive, or is in any manner part of top management, or holds an employment contract or consulting agreement, with any of the MTO's providers or in any other MTO:

☐ Yes. ☐ No. If yes, provide name(s):

v. has been, in the last five years, sanctioned, fined, prohibited from certain activities or holding certain positions, or otherwise restricted or penalized, by the US Securities and Exchange Commission (SEC):

☐ Yes. ☐ No. If yes, provide name(s):

c. In the last 12 months, has there been a change in the MTO's senior operating executive (i.e., the CEO or equivalent), Medical Director, senior financial executive, or in audit firms, or in the person to whom the MTO's senior operating executive reports (at a parent, if any):

☐ Yes. ☐ No. If yes, please identify:

11. Board. Does the MTO have a Board of Directors?

☐ Yes. ☐ No.

If yes:

a. indicate the number of members: _____

b. list the full name of each. Indicate beside each name whether the person is an employee of the MTO, or an employee, corporate officer, or Board of Directors member of the MTO's parent or any Affiliate. Use additional page if needed.

12. Type of ownership of MTO (select one):

a. ☐ Privately held or controlled by one entity or individual or agency, etc.

b. ☐ Privately held or controlled by more than one entity or individual or partner, etc (but not publicly traded or listed on a stock exchange).

c. ☐ Governmental Entity (e.g. owned by / controlled by / part of a County).

d. ☐ Owned by multiple unaffiliated stock holders, where stock is listed and can be traded on a stock exchange, wherein no individual or entity, or affiliated group of individuals or entities, has control.

e. ☐ Other. Describe/explain:

13. Owner's name. If ownership status box (a), (b), (c), or (e) was selected above, list the full legal name(s) of the direct owner(s) or controlling entity:

(continued on next page)

14. Ownership chain.

a. Does the direct owner/parent entity have a parent entity or controlling entity? If the ownership status box (a), (b), or (e) above was selected, is/are the owner(s) listed under Item 13 above the Ultimate Owner(s) (as defined under Section A Item 15) of the MTO?

☐ Direct owner *is* the Ultimate Owner (i.e., the owner listed under Item 13 is not in turn privately held or controlled)

☐ Direct owner is *not* the Ultimate Owner (i.e., the owner listed under Item 13 is in turn privately held or controlled)

b. If the answer to (a) above indicates that the Direct owner is *not* the Ultimate Owner, are there one or more entities between the direct owner/parent and the Ultimate Owner (as defined in Item 15 below)?

☐ Yes. ☐ No.

If yes, list the chain of ownership/control, on the attached page labeled as **Exhibit A-1**. For each entity between the direct owner/parent and the Ultimate Owner, provide: mailing address, phone number, website address (if any), name and title of top officer, state of incorporation, EIN (Employer Identification Number), and profit/non-profit organizational status indication. Also include this information for the direct owner/parent.

15. Ultimate Owner's name. The "Ultimate Owner" means the legal entity (or individual) that is the final and top-most owner (or controlling entity) of the MTO, and is not owned/controlled by any other party or parties. That is to say, the Ultimate Owner(s) is/are either a publicly-traded corporation, or private person(s), a domain of a governmental body, or an independent non-profit foundation/charity (wherein the foundation does not in turn have one or more controlling members), etc. There may be one or more legal entities between the direct owner and the Ultimate Owner. For purposes herein, in the case of publicly-traded corporations listed on a stock exchange, the Ultimate Owner is considered to be the public corporation, rather than the stockholders who own shares in the public corporation, so long as no stockholder owns more than 20%, and no stockholder has effective control over the corporation.

If the answer to Item 14 above indicates that the direct owner is *not* the Ultimate Owner, then list the full legal name of the Ultimate Owner(s). (There should be more than one name *only if* the ultimate ownership is divided. If so, state the ownership share proportions. This should rarely be the case, such as joint ventures/partnerships.) If the answer to Item 14 above indicates that the direct owner is also the Ultimate Owner, then repeat the answer to Item 13 here.

Ultimate Owner: _____

(continued on next page)

16. Description of Ultimate Owner. For the items below, use separate page(s) for each owner if there is more than one Ultimate Owner (i.e., divided ownership). If there is divided ownership, indicate if there is, or is not, any affiliation or any relationship as spouse, parent, child or sibling between any of the owners.

    a. With respect to the Ultimate Owner(s) shown in Item 15, list on the attached page labeled as **Exhibit A-2** the same information for this owner as was requested for the MTO in Items 1 through 6 above, plus Items 8, 10, and 11 above, as well as 18 and 19 below, and any other items that may be specified on Exhibit A-2.

    b. Indicate if the Ultimate Owner(s) is (are) related as spouse, parent, child or sibling to any person or entity with a 5% or more ownership in any other MTO or in *any* Medicaid provider.

17. Change in ownership or control. Indicate any changes with respect to either the MTO or its Ultimate Owner. This would exclude normal market stock transactions for MTOs (or Ultimate Owners of MTOs) that are publicly-traded corporations listed on a stock exchange, assuming that the stock purchase or sale:

    - does not result in a change of either the majority ownership, or of effective control of the corporation; and,
    - with respect to any given buyer (or seller), represents transactions that aggregate to no more than 15% of the total stock of the entity.

    a. Has there been a change in ownership or control within the last year?

    ☐ Yes. ☐ No. If yes, give date: _____ and describe: _____

    b. Do you anticipate any change of ownership or control within the next 12 months?

    ☐ Yes. ☐ No. If yes, approximately when? _____ Describe:

    _____

18. MTO financial statements. In addition to HHSC's FSR and any statements publically posted online by TDI, does the MTO produce any other financial statements (income statement, balance sheet, cash flow, statement notes//discussion//audit letters, etc)?

    ☐ Yes. ☐ No. If yes,

    a) indicate frequency: ☐ annual only; ☐ annual & quarterly, but not monthly; ☐ monthly & annually

    b) indicate if they are audited: ☐ annually; ☐ no, or very infrequently; ☐ other (explain):

    c) indicate if they are publicly disclosed: ☐ Yes. ☐ No. If yes, provide web URL or, if not on the internet, other location for obtaining copy: _____

19. Auditor. Provide the name, mailing address, main phone number, and website address of the MTO's audit firm. Also provide a contact name, with title, phone

(continued on next page)

number, physical location, and email address. Indicate the approximate number of consecutive years (to the present) that the MTO has used this audit firm as its primary financial auditor.

20. Revenues, employees, offices, etc.

a) Total MTO revenues from all sources during most recent prior full 12 months: $ _____ Million.

b) Percentage of the total MTO revenues that are from contracts with HHSC: _____%.

c) Total assets of the MTO at the end of the most recent quarter: $ _____ Million.

d) Net equity (net worth) of the MTO at the end of the most recent quarter: $ _____ Million.

e) Approximate total number of MTO employees and workers: _____.

f) Is the MTO location listed in item 3 above the top headquarters of the MTO? ☐ Yes. ☐ No.

g) # of separate MTO offices/facilities/locations in Texas: _____.

h) Approx. total square footage of MTO offices/facilities/locations in Texas: _____.

B. Parties-in-Interest.

"Parties-in-Interest" is a broad term that includes Affiliates as well as other entities and individuals that may not have an ownership connection. For example, the MTO's Parties-in-Interest includes all of the following (where such individuals may be associated with either the MTO or any of its Affiliates): Board of Directors members, corporate officers, executives, partners, and the relatives of such individuals.

Since Medicaid is funded in part by the Federal government, the program is subject to various Federal rules, regulations, and laws. As such, contracting parties, such as MTOs, as well as those who subcontract with MTOs, are subject to various disclosure (and other) requirements concerning Affiliates and the broader category of Parties-in-Interest. In addition to listing ownership and control information, other information is required concerning transactions with such parties that involve any of the following:

☐ 1. the leasing or sale of property;

☐ 2. mortgages, notes, and the lending of money or extension of credit;

☐ 3. rights to a percentage of profits; and

(continued on next page)

4. certain day-to-day business transactions *[NOT REQUIRED AT PRESENT]*

See the attached **Exhibits B-1 through B-3** (in landscape mode) for the format to report Affiliate and Parties-In-Interest transactions with respect to these classifications. Check each box above for which the corresponding page is attached with a positive response.

C. Criminal convictions, or debarment/suspension.

If any of the questions below are answered "Yes," list names and addresses of individuals, corporations, or other entities on the page labeled **Exhibit C**. Indicate the question number and the person's (or organization's) name, the type of conviction/exclusion, etc., and whether it is related to any program under Medicare, Medicaid, or Title XX.

For purposes herein, "ownership or control" also encompasses having *any* rights to profits.

1. Criminal convictions.

   a. *Entities with ownership or control.* Are there any individuals or organizations having a direct or indirect ownership or control interest of five percent or more of the MTO (or of its subsidiaries, direct owner/parent, or Ultimate Owner) that have been convicted of a criminal offense?

   ☐ Yes. ☐ No.

   b. *Management and other individuals.* With respect to the MTO (including the MTO's subsidiaries, its parent, its Ultimate Owner, and any other Affiliates with whom the MTO has transactions), are there any Board of Directors members, corporate officers, executives, partners, agents, or persons with employment contracts or consulting contracts over $125,000 that have ever been convicted of a criminal offense?

   ☐ Yes. ☐ No.

   c. *Relatives of Individuals.* With respect to the individuals inquired about in Items 1(a-b) above, are any of them related as spouse, parent, child or sibling to anyone that has been convicted of a criminal offense involving Medicaid, Medicare, or any government procurement, government contract, or regulatory filing or reporting?

   ☐ Yes. ☐ No.

2. Debarment, suspension, or exclusion.

   a. *Employees and certain individuals.* With respect to the MTO (including the MTO's subsidiaries, its parent, its Ultimate Owner, and any other Affiliates with whom the MTO has transactions), are there any Board of Directors members, corporate officers, executives, partners, agents, or persons with employment contracts or consulting contracts over $125,000 that have ever been debarred, suspended, or otherwise excluded (by law or by the government) from participating in any contract paid with Federal or State funds, or in government procurement activities under either:

(continued on next page)

- the Federal Acquisition Regulation (FAR) [reference https://www.acquisition.gov/far/current/html/Subpart%209_4.html], *or*
- Executive Order No. 12549 [reference 3 CFR 1986 Comp., p. 189]?

This would include any instance where the individual is or was listed on the Office of Inspector General List of Excluded Individuals and Entities (LEIE), the General Services Administration (GSA) Excluded Parties List System (EPLS), a state exclusion list, the Medicare exclusion database, or any similar list.

☐ Yes. ☐ No.

See also the HHSC Certification regarding debarment, etc.

b. *Relatives.* With respect to the employees and individuals inquired about in Item 2(a) above, are any of them related as spouse, parent, child or sibling to anyone that has been debarred, suspended, or otherwise excluded (by law or by the government) from participating in any contract paid with Federal or State funds, or in government procurement activities (as further described in Item 2(a) above)?

☐ Yes. ☐ No.

c. *Subcontractors.* Does the MTO subcontract, or have any other relationship not already covered above, with any entity or individual that has disclosed to the MTO that it has been, or that the MTO knows or reasonably should have known that has been debarred, suspended, or otherwise excluded (by law or by the government) from participating in any contract paid with Federal or State funds, or in government procurement activities (as further described in Item 2(a). above)?

☐ Yes. ☐ No.

D. Largest non-affiliate subcontractors.

1. With respect to the magnitude of payments by the MTO related to the HHSC contract(s), list below the name of the MTO's five largest contractor/subcontractor/providers that are not Affiliated in any way with the MTO. *List in descending order of annual dollar payments to such entities*, and provide the approximate annual value of payments to each. Also provide a brief name for the type of service provided by each subcontractor (e.g., transportation provider, call center, claims processing, etc). Estimated amounts should be abbreviated to the nearest tenth of a million dollars (e.g., $1,200,000 = $1.2M; $943,100 = $0.9M; $61,000 = $0.1M):

	Amt ($-M),	Service	Subcontractor Name (full legal name)
a.)			
b.)			
c.)			
d.)			
e.)			

(continued on next page)

2. For each of the five entities named in Item 1 above, list the full legal name of the ultimate owner of the subcontractor:

a.)

b.)

c.)

d.)

e.)

3. Relationships.

a.) Are any of the subcontractors listed in Item 1 affiliated with each other in any way (where one is a subsidiary of the other, or wherein two of them share, directly or indirectly, a common parent, etc.)? This would include any situation wherein there is any person or entity with an ownership or controlling interest, directly or indirectly, in any of the subcontractors listed in Item 1 above, that also has an ownership or controlling interest, directly or indirectly, in one or more of the other subcontractors listed in Item 1 above.

☐ Yes. ☐ No.

If Yes, indicate which subcontractors, the relationship, and the owning/controlling entity:

b.) Is there any person with an ownership or controlling interest, directly or indirectly, in any of the subcontractors listed in Item 1 above, that is also listed above in Section A, Item 10(a) ("Senior Executives and top Management, etc.")?

☐ Yes. ☐ No.

If Yes, indicate which subcontractor(s) and which person(s) from Section A, Item 10(a):

c.) Is there any person or entity with an ownership or controlling interest, directly or indirectly, in any of the subcontractors listed in Item 1 above, that also has an ownership or controlling interest, directly or indirectly, in the MTO or any of the MTO's Affiliates?

☐ Yes. ☐ No.

If Yes, indicate which subcontractor(s), the relationship, and the owning/controlling entity:

E. Affiliate subcontractors.

1. List below the full legal names of ALL Affiliate entities with which the MTO does business. Include all Affiliates that the MTO has had transactions with in the past

(continued on next page)

twelve months, and all that the MTO anticipates it will have transactions with in the next twelve months. Affiliate entities (other than transportation providers) with annual transactions with the MTO of less than $200,000 ($0.2M) may be excluded *if* the MTO has five or more entities listed below. Note that "Affiliate" is a contractually defined term; see the contract Terms & Conditions, in the Definitions section.

List in descending order of annual dollar payments to such entities, and provide the approximate annual value of payments to each. Estimated amounts should be abbreviated to the nearest tenth of a million dollars. Also provide a brief name for the type of service provided by the Affiliate (e.g., administrative services, transportation provider, call center, claims processing, etc).

	Amt ($-M),	Service	Affiliate Name (full legal name)
a.)			
b.)			
c.)			
d.)			
e.)			

2. For each Affiliate listed above, provide the Affiliate's full address, and any DBAs used (if none, so state). If the Affiliate is owned or controlled by another entity, then list the full legal name of the Affiliate's ultimate owner; otherwise, state: *"(not owned or controlled by another entity)."* Provide the date of the most recent contract between the Affiliate and the MTO. Indicate if a full and complete executed copy of the most recent contract has already been submitted to HHSC. Use a separate page if desired.

a.) DBA:

Ultimate Owner:

Affiliate address:

Most recent contract date: _____

Most recent contract submitted to HHSC? ☐ Yes. ☐ No.

b.) DBA:

Ultimate Owner:

Affiliate address:

Most recent contract date: _____

(continued on next page)

Most recent contract submitted to HHSC? ☐ Yes. ☐ No.

c.) DBA:

Ultimate Owner:

Affiliate address:

Most recent contract date: _____

Most recent contract submitted to HHSC? ☐ Yes. ☐ No.

d.) DBA:

Ultimate Owner:

Affiliate address:

Most recent contract date: _____

Most recent contract submitted to HHSC? ☐ Yes. ☐ No.

e.) DBA:

Ultimate Owner:

Affiliate address:

Most recent contract date: _____

Most recent contract submitted to HHSC? ☐ Yes. ☐ No.

F. Solvency issues.

1. Potential solvency issues, and other indications.

a. Does the MTO (or any of its subsidiaries, its direct owner, or Ultimate Owner) anticipate the possibility of filing for bankruptcy within the next 12 months?

☐ Yes. ☐ No. If yes, approximately when? _____

b. Does the MTO (or any of its subsidiaries, its direct owner, or Ultimate Owner) have, or anticipate having any of the following in the next 12 months:

i. a negative net equity (net worth)?

☐ Yes. ☐ No.

ii. a negative “tangible net worth” (defined herein as net equity, less goodwill and other intangible assets)?

☐ Yes. ☐ No.

iii. total current liabilities that exceed total current assets?

☐ Yes. ☐ No.

(continued on next page)

c. With respect to the MTO (including its subsidiaries, its direct owner, and Ultimate Owner), and only with respect to items in excess of $250,000, are either of the two following items presently in effect: 1) a default on any covenants, terms, or conditions of any loans, notes, mortgages, or credit facilities; or 2) receipt of any (uncured or unresolved) legal Notification of Default?

☐ Yes. ☐ No.

d. Has the audit firm of the MTO (or the audit firm(s) of any of the MTO's subsidiaries, its direct owner, or Ultimate Owner) issued in any audit or set of financial statements in the last 12 months:

i. a "going concern" statement or warning? This includes any similar statement made by the MTO (or any of its subsidiaries, its direct owner, or Ultimate Owner) in a regulatory filing or in a report to shareholders or owners.

☐ Yes. ☐ No.

ii. a qualified opinion?

☐ Yes. ☐ No.

e. In the last three years, has any audit firm of the MTO (or the audit firm(s) of any of the MTO's subsidiaries, its direct owner, or Ultimate Owner) resigned, been terminated or replaced, gone out of business, been sued or served adversarial legal correspondence by the MTO or one of its Affiliates or agents, or refused to issue a written opinion satisfactory to the audited entity?

☐ Yes. ☐ No.

f. In the last two years, has the MTO suffered losses to such an extent that the MTO has had to (or anticipates that it may have to) seek or obtain capital infusion(s), lines of credit, asset sales, parental loans or other assistance, or other sources of supplemental operating cash?

☐ Yes. ☐ No.

g. In the last 12 months, on a cumulative basis, has the MTO, or its direct owner or Ultimate Owner, reduced its total organizational headcount (including contract workers, etc) by 15% or more?

☐ Yes. ☐ No.

2. Potential exit, or reduction in participation. Is the MTO anticipating a possible exit from or a material reduction in its participation in the Managed Transportation Program in Texas? This would include exiting a Region, or a related Program, or, a 15+% drop in membership levels within a given Region.

☐ Yes. ☐ No.

3. Ownership or controlling interest in certain non-Medicaid entities. Is there any person or entity with an ownership or controlling interest in the MTO that also has an ownership or controlling interest in an entity that does not participate in Medicaid but is still required to disclose certain ownership and control information due to participation in a program established under titles V, XVIII, or XX of the Social Security Act?

(continued on next page)

☐ Yes. ☐ No.

If yes, indicate each such entity's name. Use an additional page if needed.

4. Other disclosures. If the MTO believes that there is anything else that may be material to disclosure or ownership/control issues, or that *would be needed in order to avoid being possibly misleading*, please provide information on the attached page labeled as **Exhibit F**. The MTO may also use this exhibit if it wishes to provide clarifications, explanations, additional information, etc., on any topic in this document. Any such submission *cannot* be in lieu of other information required herein. MTO may *not* state "see attached Exhibit G" (or any other exhibit or attachment) as the primary answer or response to a question.

   Check here ☐ if such supplementary exhibit is attached with a positive response.

G. Exhibits attached.

Note: *All exhibits must be attached, even if the response is a negative one (i.e., nothing to report). Do not leave an exhibit blank; if there is nothing to report, so indicate on the exhibit.*

Exhibit #	Section Reference	Exhibit name
A-1:	A.14.b.	Ownership chain
A-2	A.16.	Description of Ultimate Owner
B-1	B.1.	Parties-In-Interest: leasing or sale of property
B-2	B.2.	Parties-In-Interest: mortgages, notes, and the lending of money or extension of credit
B-3	B.3.	Parties-In-Interest: rights to a percentage of profits
n\a	n\a	Parties-In-Interest: certain day-to-day business transactions *[NOT REQUIRED AT PRESENT]*
C	C	Criminal convictions, or debarment/suspension
F	F.4.	Other disclosures
		(any other attachments or extra pages provided by MTO):

(continued on next page)

H. Signed Attestation.

I hereby attest that the information contained in this MTO Disclosure Statement, including the attached exhibits, is complete, comprehensive, accurate, and not misleading, to the best of my knowledge.

Legal Signature: _____

Printed name: _____ Date signed: _____

Title: _____

(must be Chief Executive Officer, or the MTO's equivalent)

On behalf of: _____

(MTO's legal name)

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE, OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY.

[SEE EXHIBITS ATTACHED FOLLOWING THIS PAGE.]

EXHIBIT A-1 – CHAIN OF OWNERSHIP

***Reference Item A-14* of the MTO Disclosure Statement.** If the Direct owner is not the Ultimate Owner, and, there are one or more entities between the direct owner/parent and the Ultimate Owner (as defined in Item A-15. above), then list on this exhibit the chain of ownership. If such is not the case, state so here:

☐ The direct owner of the MTO is the Ultimate Owner. There are no entities between the direct owner of the MTO and the Ultimate Owner.

Otherwise, for each entity between the direct owner/parent and the Ultimate Owner, and starting with the direct owner, provide below the following information: mailing address, phone number, web-site address (if any), name and title of top officer, state of incorporation, Employer Identification Number (EIN), and profit/non-profit organizational status indication. If ownership share is less than 100%, note the share, the name of the entity holding the remainder; and provide the information described in this paragraph for the entity.

EXHIBIT A-2 – DESCRIPTION OF ULTIMATE OWNER

Reference Item A-16 of the MTO Disclosure Statement

1. Full legal name of the Ultimate Owner of the MTO (as defined in Item A-15):

_____

2. DBA, trade name(s), abbreviation, nickname, acronym, former name(s), stock ticker symbol, etc (list any and all, if different from legal name):

3. Primary street (physical) address of Ultimate Owner, including zip code, area code and main phone number:

4. Primary mailing address of Ultimate Owner, if different from physical address:

5. Web site address(es) of Ultimate Owner (list any and all home-page URLs, excluding those of subsidiaries):

6. a. State of incorporation of Ultimate Owner: _____

   b. Ultimate Owner's EIN (Employer Identification Number): _____

7. Legal status of Ultimate Owner: ☐ For-Profit ☐ Non-Profit

***** *Note*: Items #8, 9, & 10 below are not subject to the "as changes may occur" notification requirement.

8. Employees (as of the most recent quarter end):

   a. Total number of employees and workers (in the broadest sense, including all wholly-owned subsidiaries): _____

9. Revenues (as of the most recent quarter end):

   a. Annual revenues of Ultimate Owner in the last 12 months (all lines and sources of business and funds, operating and non-operating, including the MTO and all other subsidiaries): **$**_____

   b. Percentage of the Ultimate Owner's total revenues that are:

      i. contributed by the MTO: _____**%**

      ii. contributed by Medicaid/CHIP full-risk capitated managed care: _____**%**

      iii. derived in Texas: _____**%**.

10. Assets and Equity for all lines and sources of business, including the MTO and all other subsidiaries:

   a. Total assets of the Ultimate Owner (nearest preceding quarter-end): **$**_____

   b. Net Equity (net worth) of the Ultimate Owner: $_____

(continued on next page)

c. "Tangible Net Worth" (i.e., net equity, less goodwill and other intangible assets): $_____

d. Date corresponding to the above balance sheet amounts: _____

11. Types of business. Other businesses in which the Ultimate Owner engages or receives funds, directly or via subsidiaries (check all that may apply):

- ☐ Full-Risk Broker (FRB) contract for non-emergency medical transportation
- ☐ emergency ambulance services (including via helicopter, etc.)
- ☐ non-capitated Texas Medicaid (incl. FFS, DSH, UPL, PCCM)
- ☐ capitated full-risk Medicaid/CHIP in other states; if so, total # of states (incl. TX): _____
- ☐ hospital services (owns, leases, and/or operates one or more hospitals)
- ☐ physician services (directly employs groups of doctors, separate from a hospital)
- ☐ other medical provider diagnostic, or treatment services (non-hospital facilities or group practices)
- ☐ vision network
- ☐ behavioral health network
- ☐ dental network
- ☐ pharmacy benefit management or pharmacy network
- ☐ medical transportation, ambulance services, or med-evac flights, etc.
- ☐ nursing home, assisted living, Alzheimer's facilities, special needs residential facilities, senior day care, in-home care, or senior residential facilities
- ☐ Medicare and/or other government healthcare (Federal employees/retirees, military, prisons, etc)
- ☐ commercial health insurance to corporations, organizations, groups, or individuals
- ☐ claims processing or other administrative/management services for one or more unaffiliated health insurance companies
- ☐ other insurance, excluding health insurance (e.g., life, car, disability, property, liability, etc.)
- ☐ reinsurance
- ☐ healthcare-related or insurance-related consulting, research, data analysis, or similar services
- ☐ durable medical equipment, medical supplies, or related goods or products
- ☐ services (or products) that are not related to healthcare or insurance
- ☐ other (please describe):

(continued on next page)

12. Financial statement reports. Does the Ultimate Owner file, complete, or otherwise have its financials included in (check all boxes that may apply; for each checked, list usual month that the item is filed):

☐ SEC Form 10-K (Annual Report; generally for publicly-traded for-profit companies); if so, date: _____

☐ IRS Form 990 (Return of Organization Exempt from Income Tax); if so, date: _____

☐ IRS Form 1120 (US Corporation Income Tax Return), or 1120-S or other version; if so, date: _____

☐ County Hospital District (or other County or governmental entity) annual financial statements (e.g., independent accountants' or auditors' report); if so, date(s): _____

☐ County Comprehensive Annual Financial Report; if so, date: _____

☐ any other annual report or report to the community, etc; if so, date: _____

☐ financial statements (different than above) to shareholder(s), or any owner(s), creditor(s), regulatory agency or authority, employees, or other stakeholder(s); if so, date(s): _____

13. Auditor. a. Provide the firm name, mailing address, main phone number, and website address for the Ultimate Owner's current audit firm:

b. Has this same audit firm audited the Ultimate Owner for at least the last three consecutive years?

☐ Yes. ☐ No.

c. What is the date of the end of the Ultimate Owner's fiscal year? _____

d. In what month are the Ultimate Owner's annual financial statements generally completed? _____

14. Top Officer/Executive. Full name, title, and location of the top officer of the Ultimate Owner:

15. Board. Does the Ultimate Owner have a Board of Directors that appoints and oversees the top officer?

☐ Yes. ☐ No. If yes:

a. Number of members (Directors): _____

b. How are Directors elected/appointed/selected?

☐ shareholder vote/election

☐ government/political appointee

☐ other method. Describe:

(continued on next page)

c. Provide the full name of each Director, and for each, denote

1) if they do, or do not, have a position, salary, employment contract, or consulting contract with the Ultimate Owner or any Affiliate of the Ultimate Owner. If they do, also state what their title or capacity is;

2) if they do, or do not, presently have a position or title at any other company or organization. If they do, state the name(s) of the organization(s), and the title(s). Use a separate page if desired.

16. Type of ownership/control. The Ultimate Owner listed in Item # 1 above of this Exhibit A-2 is (select one):

a. ☐ a non-profit governmental agency or governmental authority (such as a County government).

b. ☐ a publicly-traded for-profit corporation whose shares are owned by multiple unaffiliated, unrelated stockholders, wherein no stockholder, or legally affiliated block of stockholders, or family-related block of stockholders, has effective control.

c. ☐ an independent charitable foundation or other tax-exempt organization (non-governmental), governed by a Board of Directors, with no higher-level ownership or control or member.

d. ☐ owned and controlled by one or more private individuals or partners, none of whom are businesses, corporations, foundations, tax-exempt organizations, or operating entities of any kind, and, wherein there is no stock listed for trade.

e. ☐ Other. Describe/explain:

17. Split ownership. If there is more than one Ultimate Owner (as per the MTO Disclosure Statement, Section A, Items # 15 and 16), complete and attach a separate Exhibit A-2 for each. Is there more than one Ultimate Owner?

☐ Yes. ☐ No. If Yes, indicate:

a. the name(s) any other Ultimate Owner here:

b. if any of the Ultimate Owners are associated by legal affiliation, or related as spouse, parent, child or sibling:

☐ Yes. ☐ No. If Yes, describe:

(continued on next page)

EXHIBIT B-1 – Parties-in-Interest: Leasing or sale of property

Reference Section B of the MTO Disclosure Statement, "Parties-in-Interest." Note that "Affiliate" is a contractually-defined term. Please indicate on this exhibit whether the MTO is involved in any leasing, sub-leasing, rental, sale, or purchase of property from, to, or with any of the following:

a.) Affiliates,

b.) Board of Directors members (of either the MTO or any of its Affiliates),

c.) corporate officers (of either the MTO or any of its Affiliates),

d.) executives (of either the MTO or any of its Affiliates),

e.) partners (of either the MTO or any of its Affiliates),

f.) spouses, parents, children or siblings of any individuals covered by Items (b) through (e) above.

List all items valued at $100,000 and above in any given 12-month period. Among other items, the leasing or sub-leasing of office space should be shown here. This Exhibit is not limited to real estate; for example, any aircraft and high-dollar-value vehicles and equipment would be included. If any such transactions, contracts, or arrangements are presently in effect, or have occurred in the past 12 months, or are presently anticipated to occur in the next 12 months, list each such item below. If none, so state here: ☐ **NONE.**

Otherwise, include the names of the parties, the nature of the transaction, the estimated dollar value, the relevant dates, and the nature of the relationship (e.g., which Item(s) (a) through (f) apply). Indicate if the dollar value is per year, or otherwise. List in descending order of dollar value. Continue on additional pages if needed.

	Est. Total $ Value	Name(s) of Party	Transaction	Dates	Relationship
1.					
2.					
3.					
4.					
5.					
6.					
7.					

(continued on next page)

	Est. Total $ Value	Name(s) of Party	Transaction	Dates	Relationship
8.					

EXHIBIT B-2 – Parties-in-Interest: Mortgages, notes, and the lending of money or extension of credit

Reference Section B of the MTO Disclosure Statement, "Parties-in-Interest." Note that "Affiliate" is a contractually-defined term. Please state on this exhibit if the MTO is involved in any mortgages, notes, or the lending of money or extension of credit to, from, or with any of the following:

a.) Affiliates,

b.) Board of Directors members (of either the MTO or any of its Affiliates),

c.) corporate officers (of either the MTO or any of its Affiliates),

d.) executives (of either the MTO or any of its Affiliates),

e.) partners (of either the MTO or any of its Affiliates),

f.) spouses, parents, children or siblings of any individuals covered by Items (b) through (e) above.

List all transactions valued at $100,000 and above in any given 12-month period, and exclude normal operational payables or receivables to or from a parent or other Affiliate due to on-going services rendered as provided for under a service agreement contract. Among other items, notes or loans from a parent should be shown here. If any such transactions, contracts, or arrangements are presently in effect, or have occurred in the past 12 months, or are presently anticipated to occur in the next 12 months, list each such item below. If none, so state here: ☐ **NONE.**

Otherwise, include the names of the parties, the nature of the transaction, the estimated dollar value, the relevant dates, and the nature of the relationship (e.g., which Item(s) (a) through (f) apply). *List in descending order of dollar value*. Continue on additional pages if needed.

	Est. Total $ Value	Name(s) of Party	Transaction	Dates	Relationship
1.					
2.					
3.					
4.					
5.					
6.					

(continued on next page)

	Est. Total $ Value	Name(s) of Party	Transaction	Dates	Relationship
7.					
8.					

EXHIBIT B-3 – Parties-in-Interest: Rights to a percentage of profits

Reference Section B of the MTO Disclosure Statement, "Parties-in-Interest." Note that "Affiliate" is a contractually-defined term. Please state on this exhibit if the MTO has extended in any manner, contingent or otherwise, any rights to a percentage or share of its profits or revenues, with any of the following:

a.) Affiliates,

b.) Board of Directors members (of either the MTO or any of its Affiliates),

c.) corporate officers (of either the MTO or any of its Affiliates),

d.) executives (of either the MTO or any of its Affiliates),

e.) partners (of either the MTO or any of its Affiliates),

f.) spouses, parents, children or siblings of any individuals covered by Items (b) through (e) above.

This excludes dividend payments to the MTO's parent that are not required, scheduled, or contractually defined. Among other items, any payments to a parent or other Affiliate, whether for services or otherwise, that are contingent upon MTO profitability levels, should be shown here. If any such transactions, contracts, or arrangements are presently in effect, or have occurred in the past 12 months, or are presently anticipated to occur in the next 12 months, list each such item below. If none, so state here: ☐ **NONE.**

Otherwise, include the names of the parties, the nature of the transaction or arrangement, the estimated dollar value, the relevant dates, and the nature of the relationship (e.g., which item(s) (a) through (f) apply). Indicate if the dollar value is per year, or otherwise. *List in descending order of dollar value*. Continue on additional pages if needed.

	Est. Total $ Value	Name(s) of Party	Transaction	Dates	Relationship
1.					
2.					
3.					
4.					
5.					
6.					

(continued on next page)

	Est. Total $ Value	Name(s) of Party	Transaction	Dates	Relationship
7.					

EXHIBIT C – Criminal convictions, or debarment/suspension

Reference Section C of the MTO Disclosure Statement, "Criminal convictions, or debarment/suspension." If any of the questions in Section C are answered "Yes," list names and addresses of individuals or corporations on this exhibit. If none, so state here: ☐ **NONE.**

Otherwise, indicate the question number (within Section C), the person's (or organization's) name, the type of conviction/debarment/suspension, etc., and whether the conviction/debarment/suspension is related to any program under Medicare, Medicaid, or Title XX. Continue on additional pages if needed.

Sect C Question #	Person/Organization Name	Address	Indicate: Conviction, Debarment, or Suspension	Regarding (what is it about?)	Indicate: Medicare, Medicaid, Title XX, or Other

(continued on next page)

EXHIBIT F – Other Disclosures

Reference Item #F-4 of the MTO Disclosure Statement, "Other Disclosures." If the MTO believes that there is anything else that may be material to financial disclosure or ownership/control issues, or that would be needed in order to avoid being possibly misleading, please provide information on this exhibit. The MTO may also use this exhibit if it wishes to provide clarifications, explanations, additional information, etc., on any topic in this document. If none, so state here: ☐ **NONE.** Continue on additional pages if needed.

Attachment N – MTO DISCLOSURE STATEMENT – CHANGE NOTIFICATION

Applicability of this document

This statement is to be completed by each Managed Transportation Organization (MTO) that contracts with HHSC to provide Managed Transportation Program (MTP) services in Texas. If an MTO contracts with HHSC under more than one legal name, then the MTO should complete a separate statement for each such legal entity. The statement discloses information about the MTO, including ownership, type of entity, Affiliates (as defined in HHSC's managed care contracts), and other related parties. The statement also discloses transactions with such parties, subcontracts, provider fraud, solvency, any criminal convictions, etc.

The statement must be submitted *only for interim reporting of changes that have occurred since the last annual filing*. All annual filings should use the full *MTO Disclosure Statement* form.

Note that HHSC's request for information regarding the existence of possible transactions, arrangements, relationships, etc., does not confer or imply allowability or unallowability of the issue under inquiry. Unless otherwise instructed, the signed statement should be submitted to HHSC as a PDF file, showing written signature. Please fill-in the date this form is submitted in the designated space at the top of Page 1 of the form.

Per Federal regulations: *A Medicaid agency shall not approve a contract, and must terminate an existing contract, if certain contractors fail to disclose certain ownership and control information* (42 CFR 455.104).

This short form is only for interim reporting of changes that have occurred since the last annual filing.
All annual filings should use the full *MTO Disclosure Statement* form.

Full legal name of MTO that contracts with HHSC:

Date of filing of this Change Notification:
Date of filing of last prior full MTO Disclosure Statement:

Note: Section headings below reference the last prior filed full *MTO Disclosure Statement*. If there have been one or more changes in a given Section, indicate them under that Section heading below, in the same format as in the full form, starting with the item number (and sub-number, if any) from the full form. Each Section must be checked either Yes or No; do not leave any Section blank.

Section A: MTO Identification and Ownership.

I. Have there been any changes to this Section, outside of Exhibits A-1 and A-2?
☐ Yes ☐ No
If YES, report all changed information here (starting with the item #):

II. Has any information regarding item 14.b, or in Exhibit A-1, changed?
☐ Yes ☐ No
If YES, attach a revised Exhibit A-1 (*Chain of Ownership*).

III. Has any information supplied in Exhibit A-2 (excluding items 8, 9, and 10) changed?
☐ Yes ☐ No
If YES, report these changes to *Description of Ultimate Owner* here:

Section B: Parties-in-Interest.

I. Have there been any changes to this Section, with respect to:
- Exhibit B-1, *Leasing or Sale of Property*?
  ☐ Yes ☐ No
- Exhibit B-2, *Mortgages, Notes, & the Lending of Money or Extension of Credit*?
  ☐ Yes ☐ No
- Exhibit B-3, *Rights to a Percentage of Profits*?
  ☐ Yes ☐ No

II. If YES to any of the above, attach a revised version of the corresponding Exhibit(s).

Section C: Criminal Convictions, or Debarment/Suspension.

I. Have there been any changes to this Section?
☐ Yes ☐ No
If YES, report which item numbers here, and which YES/NO box for each item should be checked:

II. If YES, also attach a revised Exhibit C.

(continued on next page)

Section D: Largest Non-Affiliate Subcontractors.

I. Have there been any changes to this Section?
☐ Yes ☐ No
If YES, report all changed information here:

Section E: Affiliate Subcontractors.

I. Have there been any changes to this Section?
☐ Yes ☐ No
If YES, report all changed information here:

Section F: Solvency & Other Issues.

I. Have there been any changes to items 1 through 3 in this Section?
☐ Yes ☐ No
If YES, report all changed information here (starting with the item #):

II. Have there been any changes to item 4 in this Section (or Exhibit F)?
☐ Yes ☐ No
If YES, attach a revised Exhibit F (*Other Disclosures*).

G. Exhibits.

As specified above, attach any required updated Exhibits following the Attestation section below.

H. Signed Attestation.

This *MTO Disclosure - Change Notification Short Form* amends and updates the previously filed full *MTO Disclosure Statement*, as filed by this MTO. I hereby attest that the information contained in this *Change Notification Short Form*, when combined with the most recent previously-filed *MTO Disclosure Statement*, including all attached exhibits, is complete, comprehensive, accurate, up-to-date, and not misleading, to the best of my knowledge.

Legal Signature: _____

Printed name: _____ Date signed: _____

Title: _____

(must be Chief Executive Officer, or the MTO's equivalent)

On behalf of: _____

(MTO's legal name)

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE, OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY.

Attachment O – Report of Legal and Other Proceedings and Related Events

Applicability of this document

This document is part of the Contract, and applies to Managed Transportation Organizations (MTOs) participating in the HHSC Medical Transportation Program (MTP) for non-emergency medical transportation under Medicaid.

I. Report Notification Content

The MTO must notify HHSC of all proceedings, actions, and events as specified in this document. The notice required by the following sections must be in writing and should include the:

(1) parties' names;

(2) subject matter;

(3) amount in controversy; relevant dates;

(4) a description of the general nature of any allegations; and

(5) if applicable, the case number, court, relief sought, and any known internet links to related information.

II. Matters Pertaining to the MTO or Affiliates

MTO must notify HHSC of the following matters relating to the MTO or its Affiliates, including parent companies:

(1) whistleblower or *qui tam* actions, complaints, or litigation;

(2) criminal actions brought against the MTO, or its Affiliates or officers;

(3) class-action complaints or lawsuits, or petitions for class-action status, filed against the MTO or its Affiliates;

(4) legal actions or governmental investigations, alleging fraud or the possibility of fraud; and

(5) bankruptcy proceedings or petitions where either the MTO or an Affiliate is named as debtor.

III. Matters Pertaining to the MTO or Affiliates

MTO must notify HHSC of the following matters relating to the MTO or its Affiliates, including parent companies:

(1) all known media reports involving actual, potential, or perceived misreporting of costs or profit levels;

(2) all governmental actions or proceedings involving actual, potential, or perceived misreporting of costs or profit levels;

(3) subject to the exclusions listed in Section VII, other governmental actions or proceedings involving the assessment of sanctions, remedies, fines, or penalties, including Liquidated Damages, in excess of $500,000.

For purposes of this section, the MTO is not required to notify HHSC of governmental actions or proceedings initiated by HHSC.

IV. Matters Pertaining to the MTO or Parent Company

MTO must notify HHSC of any legal proceedings that could have an adverse material effect on the financial condition or results of operations of the MTO or its parent company.

For purposes of this section, "material effect" means an impact that could rise to the level of:

(1) requiring or warranting disclosure in:

(A) an audited financial statement submitted to a state Department of Insurance (such as TDI);

(B) financial statements filed with the Securities and Exchange Commission; or

(C) reports distributed to shareholders, owners, or prospective investors;

(2) anything that a reasonable person knowledgeable in the industry would consider relevant to the entity's operations or financial position, or any development that reasonable person would want to know in order to stay fully apprised of the information relevant to the industry and its operations; or

(3) anything that an independent financial auditor would consider material.

V. Matters Pertaining to the MTO, its Parent Company, or Material Subcontractors

MTO must notify HHSC of any known event that could threaten solvency, or the ability to continue operations of the MTO, its parent company, or any Material Subcontractor.

VI. Other Matters Pertaining to the MTO

Subject to the exclusions listed in Section VII, MTO must notify HHSC of the following matters pertaining to the MTO:

(1) litigation, mediation, arbitration, and dispute resolution proceedings; and

(2) governmental complaints, investigations, and corrective actions.

VII. Exclusions

The following matters related to the MTO or its Affiliates are excluded from the requirements of Section III, Subsection (3). In addition, the following matters related to the MTO are excluded from the requirements of Section VI, provided the worst-case outcome would not have an adverse material effect on the financial condition or results of operations of the MTO, as defined in Section IV:

(1) personnel actions, including wrongful discharge, discrimination, or harassment, if the actions do not involve whistleblower claims;
(2) property damage;
(3) personal injury claims, where there is no related issue involving the provision of medical services or coverage;
(4) landlord/tenant issues;
(5) equipment vendor issues;
(6) lease issues;
(7) mechanic's liens;
(8) provider claims adjudication appeals;
(9) complaints, actions, litigation, or disputes with HHSC;
(10) trademark, patent, or other intellectual property disputes; and
(11) any other matter, which is not required for disclosure under Sections II–VI and where the amount claimed and at stake continues to be less than $500,000 or its value in non-cash components, including the total of alleged or potential damages, relief, penalties, costs, fines, interest, legal fees, arbitration fees, court costs, and all components.

VIII. Notice Requirements

The MTO must provide written notification within 30 calendar days after becoming aware of a matter. In addition, by September 1 of each year, the MTO must submit a cumulative annual report listing all current or pending matters, and all matters resolved or dismissed during the past 12 months.

The initial and annual notices must include a signed certification by the MTO's Chief Executive Officer or President that all required items are listed in the written notice, or that no matters have transpired.

The knowledge and information of an MTO, its parent, Affiliates, and Material Subcontractors is not required to exceed knowledge or information normally possessed by a prudent person in the ordinary course of business dealings.

IX. Additional Information

HHSC may require that the MTO provide appropriate supplementary information or keep HHSC informed of further developments and related activities.

X. Confidentiality

If the MTO believes that all or a portion of the notification information or supplementary information provided in this report is confidential under applicable state or federal law, it should follow the applicable procedures set forth in the Contract and mark or otherwise identify the information as "confidential." To the extent authorized by Texas law, HHSC will treat the marked information as

confidential, and limit access to personnel HHSC deems necessary for the administration of this Agreement.

If a court order or confidentiality agreement restricts the disclosure of all or part of the information described in this Attachment, then the MTO may request a written exception to this required report from.

Attachment P – Audit Reports

Applicability of this document

This document is part of the Contract, and applies to Managed Transportation Organizations (MTOs) participating in the HHSC Medical Transportation Program (MTP) for providing nonemergency medical transportation services.

I. Definitions – for purposes of this document only, the following terms mean:

"Audit Reports" is hereby defined in a broad sense, including but not limited to: financial audits; attestation engagements; compliance examinations; fraud assessments; assessments of legal and/or regulatory compliance; risk assessments; Affiliate transaction assessments; disbursement audits or reviews; financial or fiscal inspections; other financially-related audits, and related reviews, reports, studies, analysis, and filings; and any related audit communications, including without limitation audit letters. The term includes Audit Reports conducted by or on behalf of, or administered to, the MTO, provided that any part of the Audit Report directly relates to the Relevant Business.

For the purposes of this document only, "Audit Reports" do *not* include daily, weekly, or monthly claims audits; claims system audits; claims payment operational audits; audits for billing and coding errors; reports on claims, enrollment, or Member service activities; internal quality control audits; or quality improvement reviews.

"External Audit Reports" are Audit Reports that are conducted for use by outside parties, including without limitation the Securities and Exchange Commission, shareholders, creditors, rating entities, analysts, regulatory bodies, and/or prospective investors. External Audit Reports generally are prepared by an outside party, such as external audit firms, consultants, advisors, contractors, governmental bodies, or regulatory authorities. Typically, External Audit Reports are prepared to comply with laws, credit requirements, or regulations governing the MTO.

"Internal Audit Reports" are Audit Reports that are conducted primarily for purposes of internal MTO management use, and that are not disclosed outside the MTO. Internal Audit Reports are generally prepared by one or more employees of the MTO, such as internal audit departments; financial or accounting personnel; or internal analysts, staff, or management. Internal Audits may, however, be conducted by an external accounting firm, consultant, or other external entity retained by the MTO, if conducted for the MTO's internal use only. An Audit Report that meets all the definitional requirements of being deemed an Internal Audit Report, with the one exception that the report is shared with a parent corporation, but is not otherwise distributed externally, shall be deemed an Internal Audit Report. Any Audit Report that does not meet the requirements to be deemed an Internal Audit Report shall be deemed an External Audit Report.

"Relevant Business" means the HHSC Managed Transportation Program, the HHSC Full-Risk Broker contract, Texas STAR, STAR+PLUS, CHIP, STAR Health, Dental, and/or the Texas Medicaid or CHIP business.

II. Reporting Requirements –

1) *External Audit Reports*: The MTO must provide HHSC or its designee with copies of all External Audit Reports issued on or after the Effective Date of the Contract. The MTO must provide electronic copies of the HHSC required annual audit of the MTOs financial statements within four (4) months of the end of the MTOs fiscal year, and must provide electronic copies of all other External Audit Reports within 45 days of the issue date of the report. The MTO does not need to submit a draft version of External Audit Reports, provided that it completes a final version of such report within 45 days of the draft.

2) *Internal Audit Reports*: The MTO must notify HHSC or its designee of all Internal Audit Reports issued on or after the Effective Date of the Contract. The MTO must provide such notice, including the date of issuance and a general description of the audit's topic, within 45 days after the report is issued. The MTO must make Internal Audit Reports available for review at its Texas office within five business days of the deadline for providing the notice. If the MTO has more than one Texas office, HHSC may choose the facility for conducting the review. The MTO is not required to notify HHSC or its designee of a draft version of an Internal Audit Report if the final version is completed within 45 days of the draft.

3) The MTO may redact or withhold those portions of Audit Reports that are privileged from discovery by a court order or under the Texas Rules of Civil Procedure, Texas Rules of Evidence, or other applicable state or federal law. The MTO must provide HHSC or its designee with a general written description of the redacted or withheld information, as well as the basis for the MTO's belief that such information is privileged from discovery.

4) The MTO may also redact or withhold those portions of Audit Reports that do not pertain in any way to the Relevant Business. In such case, the MTO must provide HHSC or its designee with a general written description of the redacted or withheld information.

5) If the MTO believes that all or a portion of the information provided pursuant to this requirement is confidential under applicable state or federal law, it should follow the procedures set forth in the Contract Terms and Conditions, and mark or otherwise identify the information as "confidential." To the extent authorized by Texas law, HHSC will treat such information as confidential, and limit access to personnel HHSC deems necessary for the administration of this Agreement.

6) With a written exception from HHSC, the MTO will not be required to produce all or part of an Audit Report that the MTO judges to be either substantial in volume, repetitious in its periodic schedule, immaterial, or irrelevant. If the MTO requests an exception prior to the Audit Report's submission deadline, HHSC will suspend the deadline while considering the request.

7) The MTO may submit an Audit Report to HHSC with no change in format, if the MTO has already submitted the report to another state, Federal, or other governmental agency.

8) The MTO is not required to resubmit an Audit Report already submitted to HHSC, unless requested in writing by HHSC. In lieu of resubmission, the MTO must provide HHSC with the name of the Audit Report, the date submitted to HHSC, and the recipient's name.

9) The requirements set forth above do not, in any way, limit HHSC's rights under the Contract Terms and Conditions or any other section of the Contract.

Attachment Q – HHSC classification of Counties as "urban" or "rural," with respect to nonemergency medical transportation

Applicability of this document

This document is part of the Contract, and applies to Managed Transportation Organizations (MTOs) participating in the HHSC Medical Transportation Program (MTP) for providing nonemergency medical transportation services.

I. Summary overview

There are various ways to classify counties as either urban or rural. HHSC has developed a classification methodology to be applied primarily for the purpose of HHSC's cost tracking for non-emergency medical transportation. As such, this method does not rely solely on the aggregate population of a county, but also considers the county's average population density, and may incorporate other considerations, such as the local transportation infrastructure (roads, mass transit, taxi, etc.) and the local medical services infrastructure (the presence of hospitals and the relative supply of medical services providers). These factors will impact average trip distances and related issues with respect to medical transportation. HHSC's methodology and classification herein is subject to change.

Texas has 254 counties, and a population of about 25 million people. Approximately 21 million of the state's population resides in just 42 of the state's counties. The population density (the average number of people per square mile) is more than 25 times greater for the average of the 42 counties, when compared to the average of the other 212 counties. Thus, the majority of counties in Texas are essentially rural, while the majority of the population lives in more densely-populated counties, which may be deemed to be urban. HHSC's methodology herein results in the following split:

	# of Counties	approx. population	approx. # of sq. miles	avg. density: pop / sq mile
"urban"	42	20,800,000	39,314	530
"rural"	212	4,300,000	221,919	19
total state	254	25,100,000	261,233	96

II. Definitions – for purposes of this document only, the following terms mean:

"Urban County" is herein defined as a Texas County that meets *any* of the following three criteria:

- has a County population of at least 75,000 while also having an average population density of at least 110 people per square mile; or,
- has a population over 100,000; or,
- has a population density of at least 120.

"Rural County" is herein defined as any County that is not classified as an Urban County.

A list of the state's Counties are as follows in the next section.

III. List of Counties –

Anderson	rural
Andrews	rural
Angelina	rural
Aransas	rural
Archer	rural
Armstrong	rural
Atascosa	rural
Austin	rural
Bailey	rural
Bandera	rural
Bastrop	rural
Baylor	rural
Bee	rural
Bell	urban
Bexar	urban
Blanco	rural
Borden	rural
Bosque	rural
Bowie	rural
Brazoria	urban
Brazos	urban
Brewster	rural
Briscoe	rural
Brooks	rural
Brown	rural
Burleson	rural
Burnet	rural
Caldwell	rural
Calhoun	rural
Callahan	rural
Cameron	urban
Camp	rural
Carson	rural
Cass	rural
Castro	rural
Chambers	rural
Cherokee	rural
Childress	rural
Clay	rural
Cochran	rural
Coke	rural
Coleman	rural
Collin	urban
Collingsworth	rural
Colorado	rural
Comal	urban
Comanche	rural
Concho	rural
Cooke	rural
Coryell	rural
Cottle	rural
Crane	rural
Crockett	rural
Crosby	rural
Culberson	rural
Dallam	rural
Dallas	urban
Dawson	rural
Deaf Smith	rural
Delta	rural
Denton	urban
DeWitt	rural
Dickens	rural
Dimmit	rural
Donley	rural
Duval	rural
Eastland	rural
Ector	urban
Edwards	rural
El Paso	urban
Ellis	urban
Erath	rural
Falls	rural
Fannin	rural
Fayette	rural
Fisher	rural
Floyd	rural
Foard	rural
Fort Bend	urban
Franklin	rural
Freestone	rural
Frio	rural
Gaines	rural
Galveston	urban
Garza	rural
Gillespie	rural
Glasscock	rural
Goliad	rural
Gonzales	rural
Gray	rural
Grayson	urban
Gregg	urban
Grimes	rural
Guadalupe	urban
Hale	rural
Hall	rural
Hamilton	rural
Hansford	rural
Hardeman	rural
Hardin	rural
Harris	urban
Harrison	rural
Hartley	rural
Haskell	rural
Hays	urban
Hemphill	rural
Henderson	rural
Hidalgo	urban
Hill	rural
Hockley	rural
Hood	urban
Hopkins	rural
Houston	rural
Howard	rural
Hudspeth	rural
Hunt	rural
Hutchinson	rural
Irion	rural
Jack	rural
Jackson	rural
Jasper	rural
Jeff Davis	rural
Jefferson	urban
Jim Hogg	rural
Jim Wells	rural
Johnson	urban

Jones	rural	Montgomery	urban	Somervell	rural
Karnes	rural	Moore	rural	Starr	rural
Kaufman	urban	Morris	rural	Stephens	rural
Kendall	rural	Motley	rural	Sterling	rural
Kenedy	rural	Nacogdoches	rural	Stonewall	rural
Kent	rural	Navarro	rural	Sutton	rural
Kerr	rural	Newton	rural	Swisher	rural
Kimble	rural	Nolan	rural	Tarrant	urban
King	rural	Nueces	urban	Taylor	urban
Kinney	rural	Ochiltree	rural	Terrell	rural
Kleberg	rural	Oldham	rural	Terry	rural
Knox	rural	Orange	urban	Throckmorton	rural
La Salle	rural	Palo Pinto	rural	Titus	rural
Lamar	rural	Panola	rural	Tom Green	urban
Lamb	rural	Parker	urban	Travis	urban
Lampasas	rural	Parmer	rural	Trinity	rural
Lavaca	rural	Pecos	rural	Tyler	rural
Lee	rural	Polk	rural	Upshur	rural
Leon	rural	Potter	urban	Upton	rural
Liberty	rural	Presidio	rural	Uvalde	rural
Limestone	rural	Rains	rural	Val Verde	rural
Lipscomb	rural	Randall	urban	Van Zandt	rural
Live Oak	rural	Reagan	rural	Victoria	rural
Llano	rural	Real	rural	Walker	rural
Loving	rural	Red River	rural	Waller	rural
Lubbock	urban	Reeves	rural	Ward	rural
Lynn	rural	Refugio	rural	Washington	rural
Madison	rural	Roberts	rural	Webb	urban
Marion	rural	Robertson	rural	Wharton	rural
Martin	rural	Rockwall	urban	Wheeler	rural
Mason	rural	Runnels	rural	Wichita	urban
Matagorda	rural	Rusk	rural	Wilbarger	rural
Maverick	rural	Sabine	rural	Willacy	rural
McCulloch	rural	San Augustine	rural	Williamson	urban
McLennan	urban	San Jacinto	rural	Wilson	rural
McMullen	rural	San Patricio	rural	Winkler	rural
Medina	rural	San Saba	rural	Wise	rural
Menard	rural	Schleicher	rural	Wood	rural
Midland	urban	Scurry	rural	Yoakum	rural
Milam	rural	Shackelford	rural	Young	rural
Mills	rural	Shelby	rural	Zapata	rural
Mitchell	rural	Sherman	rural	Zavala	rural
Montague	rural	Smith	urban		

Attachment R – Affiliate Report

Applicability of this document

This document is part of the Contract, and applies to Managed Transportation Organizations (MTOs) participating in the HHSC Medical Transportation Program (MTP) for providing non-emergency medical transportation services. Note "Affiliate" is a defined term in the Definitions section of the Contract.

I. Report schedule

The MTO must submit an Affiliate Report for each of the following:

1. during Readiness Review (by the date identified in the Contract);
2. annually by September 1 each year; and
3. on an as-occurs basis.

The "as-occurs" update is due within 30 days of the event triggering the change. A triggering event is any change in the information provided under Section II(2)(a), "Transactions types for each Affiliate." An as-occurs update is not required if all three of the following are true:

1. the only change is a revision in the aggregate annual dollars estimated for a transaction;
2. the revision is less than a 10% change (cumulative since the last Affiliate Report filed); and,
3. there was no change in pricing terms.

Any change in pricing terms (other than for providers), regardless of the percentage impact, requires both an update of the report and HHSC's prior written approval.

The annual submission is due in full every year, even if there have been no changes.

II. Report contents

The Affiliate Report must contain the following:

1. Affiliates.
    a. Affiliate list. A list of all Affiliates with whom the MTO has, or may have, any transactions or business, where such transactions or business might be included as expenses in the FSR.

For each Affiliate, include the estimated annual aggregate dollars in FSR-recorded transactions between the MTO and the Affiliate. List Affiliates in descending order of aggregate annual FSR dollars.

b. Affiliate descriptions. For each listed Affiliate, the MTO must:

i. Indicate the basic nature of the Affiliate relationship (e.g., parent, wholly-owned subsidiary, sister company under common ownership)

ii. Indicate the Affiliate's total annual revenues from all sources, and also indicate the portion from external non-affiliated sources.

iii. Indicate the number of employees (staff and management) that are dedicated full-time to the Affiliate's business. Provide the approximate square feet of office space dedicated solely to the Affiliate's business. Indicate the locations of these employees and office space.

iv. Provide an organizational chart for the Affiliate, showing key personnel of the Affiliate (name and title), their location, and whether they are dedicated full or part-time to the Affiliate's business. Indicate the person (name and title) to whom the top executive of the Affiliate reports.

v. Indicate if any of the Affiliate's staff are located in the same office building or complex as any of the MTO's staff. If so, the MTO must indicate what proportion of the Affiliate's total staff is co-located with the MTO.

vi. Indicate if any of the Affiliate's staff are employed by the same legal entity as the MTO's employees. If so, identify the proportion of the Affiliate's staff that is employed by the entity.

2. Transactions

a. Transaction types for each Affiliate. For HHSC's prior review, provide a schedule of each type of transaction the MTO anticipates may incur with each Affiliate listed above. The schedule must show each type of service and transaction that, under the provisions of the Contract, would be recorded as an expense in the FSR. The schedule must include financial and pricing terms for each proposed transaction type, including:

i. A description of each service to be provided (for example, “parental administrative services, including accounting, legal, & claims processing,” “transportation provider,” or “call center”);

ii. An estimated aggregate annual dollar amount for each service or transaction that may be incurred by the MTO during the State Fiscal Year;

iii. Any per-unit, per-member-per-month (PMPM), percentage, fixed monthly, or other basis of Affiliate pricing to the MTO;

iv. A list of the types of costs incurred by the Affiliate and included in the price to the MTO (e.g., payroll costs; facilities occupancy costs; insurance; depreciation and amortization; travel, gas, vehicle maintenance);

v. Any Affiliate overhead allocation methods included in the price to the MTO; and

vi. Any assumed mark-ups or margins between related entities, etc. Indicate whether there are, or are not, any mark-ups, margins, profits, or add-ons, or any assessments or allocations that HHSC or its external auditor determine are similar.

Note that HHSC’s prior written approval is required for any changes in proposed pricing or other terms with Affiliates during the Term of the Contract. HHSC’s approval does not exempt the Subcontract from audit, nor from the requirement to conform to the Contract’s requirements, including the Cost Principles.

b. Transaction background and comparative information. For each Affiliate transaction listed on the schedule, identify:

i. The proportion of the Affiliate’s total annual revenues that the MTO’s estimated annual payments under the proposed Affiliate transaction would represent.

ii. Whether the Affiliate provides the same or similar services to any unaffiliated external entity. If so, provide the Affiliate’s pricing terms with unaffiliated entities.

iii. Whether the Affiliate provides the same or similar services to another Affiliate. If so, indicate whether that price is ever lower than the price for the Affiliate transaction listed on this schedule.

iv. Whether the MTO has procured the same or similar services from a non-Affiliate. If the MTO has done so in the last 5 years, indicate

the names of any unaffiliated suppliers, and the prices of these services from the unaffiliated suppliers.

III. Signed Attestation

The Affiliate Report must conclude with the following (including the statement at the end):

I attest that the information contained in this Affiliate Report, including any attached exhibits, is complete, comprehensive, accurate, and not misleading, to the best of my knowledge.

Legal Signature: _____

Printed name: _____ Date signed: _____

Title: _____

(must be Chief Executive Officer, or the MTO's equivalent; no delegation)

On behalf of: _____

(MTO's legal name)

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE, OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY.

Nonemergency Medical Transportation
Managed Transportation Organizations (MTOs)
Key Performance Requirements
RFP No. 529-15-0002

Performance measures are applicable at all times and may be monitored accordingly. Accelerated monitoring may occur as needed. Performance standard will be applied to regular monitoring visits or any other follow up or occurrence as deemed necessary by HHSC. Performance Measures may not be subject to more than one Performance Standard and associated Liquidated Damage assessment.

Definitions

"Performance Standard" refers to the specific, desired or required outcome or result of the MTO's performance
"Performance Measure" refers to the specific number, amount, percentage or duration of the activity or deliverable described in the Performance Standard
"Monitoring Period" refers to the specific period of time during which the MTO's performance will be monitored for compliance with the Performance Standard and subject to potential remedies under the contract
"Cure Period" refers to the time specified as a grace period in this document for each Performance Measure during which the MTO may perform the required service or supply the required deliverable
"Base Liquidated Damage Value" is the dollar amount HHSC will apply to each unit or instance of noncompliance with a Performance Measure

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
MTO 1	Section 1.6.2	Service Delivery The MTO must arrange, coordinate, schedule, and provide transportation services to meet the needs of the client	98% of all services must be arranged, coordinated, scheduled, dispatched and provided to meet the clients' needs	Quarterly unless accelerated by HHSC	0 calendar days	$1,500 per percentage point below 98% when the service is not delivered.
MTO 2	Section 2.3.10.11	The monthly average maximum wait (before answered by a live person) will not exceed 900 seconds, inclusive of all IVR time, for calls other than from or on behalf of a child birth through 20, with Medicaid. (see § 2.35.9 for calculation	Monthly average maximum wait of 900 seconds, or less, for calls other than from or on behalf of a child birth through 20 with Medicaid.	Monthly	n/a	$2,500 for the first month in which the average maximum wait times fail to meet the monthly standard specified related to the client toll free line for transportation services, for those calls determined to be from other than or on behalf of a child

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		methodology). This measure is calculated as follows: 1. The MTO must track the length of the call that had the longest wait prior to speaking to a live person, each day. 2. The wait time includes all time spent in the IVR (or auto-attendant) as well as the time waiting in queue. 3. The length of each daily call with the longest wait, prior to speaking to a live person for the month will be combined and divided by the total number of business days in the month, 4. The resulting number must not exceed 300 seconds.				birth through 20 with Medicaid. Liquidated damages will continually increase by $1,250 for each subsequent, consecutive month that non-compliance continues.
MTO 3	Section 2.3.10.11	The average monthly wait to speak to a live person after the IVR message and conclusion of user selection of menu items, for calls from callers other than from or on behalf of a child birth through 20 with Medicaid. This measure is derived by dividing the total monthly time in queue for these calls	Monthly average speed of answer to a live agent will not exceed 180 seconds, for calls from callers other than from or on behalf of a child birth through 20 with Medicaid.	Monthly	n/a	$2,500 for the first month in which the average monthly wait to speak to a live person fails to meet the monthly standard specified herein, related to the client toll free line for transportation services, for those calls determined to be from callers other than from or on behalf of a child birth through 20 with Medicaid.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		(placed by callers other than from or on behalf of a child birth through 20, with Medicaid), by the number of answered calls for the month (placed by callers other than from or on behalf of a child birth through 20, with Medicaid), during the hours specified in §2.3.10.1.				Liquidated damages will continually increase by $1,250 for each subsequent, consecutive month that non-compliance continues.
MTO 4	Section 2.3.10.11	The number of calls that abandon, after conclusion of any IVR (or auto-attendant) selections, determined to be placed by callers other than from or on behalf of a child birth through 20, with Medicaid, during hours referenced in §2.3.10.1. This measure is determined as follows: The percentage of calls received from callers other than from or on behalf of a child birth through 20, with Medicaid during each month that are abandoned, after conclusion of any IVR (or auto-attendant) selections, determined to be placed by callers from or on behalf of a child birth through 20, with Medicaid, during hours referenced in §2.3.10.1. The	Monthly abandon rate will not exceed 12%, for calls from callers other than from or on behalf of a child birth through 20 with Medicaid.	Monthly	n/a	$2,500 for the first month in which the MTO fails to meet the monthly standard specified in §2.3.10.11 related to the client toll free line for transportation services, for those calls determined to be from callers other than from or on behalf of a child birth through 20 with Medicaid. Liquidated damages will continually increase by $1,250 for each subsequent, consecutive month that non-compliance continues.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		monthly total for this measure is divided into the monthly total calls received, after conclusion of any IVR (or auto-attendant) selections, determined to be placed by callers from or on behalf of a child birth through 20, with Medicaid, during hours referenced in §2.3.10.1.				
MTO 5	Section 2.3.11	The MTO's monthly report will include individual exam scores on new materials for MTO staff who answered calls for the prior month. "New materials" shall include training for new staff or training of existing staff on new or updated materials. The MTO's monthly report will include individual exam scores on retraining for MTO staff who answered calls for the prior month. "Re-training" shall include those staff, that call monitoring indicates a need for re-training. MTO staff who do not achieve the minimum required score for each exam on new materials and/or	For staff answering calls from MTP eligible clients, each individual must achieve a minimum score of 85% or better on all new material exams or re-training exams.	Each month in which staff answers calls from MTP eligible clients.	n/a	$250 for each occurrence. "Occurrence" is defined here as each new material exam score or re-training exam score below 85% (the most recent exam on the topic) per staff who answered calls from MTP eligible clients during the month. It is not required that all MTO staff meets the 85% on the first try. Individuals failing to meet or exceed that minimum must not answer calls from MTP eligible clients until they are re-tested and able to achieve a score of 85% or better. Exam questions for staff being re-tested must be sufficiently different, to discourage memorization of the previous exam answers.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		retraining must not answer calls until the required scores are achieved, via initial test or re-test. MTO must submit and certify the summary testing and/or re-testing report to HHSC by the 2nd business day of the month following any month in which MTO staff answers calls. The monthly report must be submitted in a media and format approved by HHSC.				Liquidated damages will continually increase by $125 (per exam, per staff) for each subsequent, consecutive month that non-compliance continues, for that particular MTO staff. Example: the MTO new hire training are comprised of 10 exams. MTO Agent A scores 85% or better on 8 of those exams and 70% on the remaining two exams. If MTO Agent A answers calls from MTP eligible clients during the month, liquidated damages of $500 are due (two exam scores below 85%). However, if MTO Agent A re-takes the two exams in question and eventually achieves 85% or greater on both of them before answering calls from MTP eligible clients, no liquidated damages are due for this measure for Agent A. "Re-test" is defined as a subsequent attempt to achieve the required score by an individual, on a test, per topic. Note that re-test is different from re-training

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						(see definition of re-training below). The monthly summary testing report will indicate the MTO staff who answered calls from MTP eligible clients for the prior month and the most recent individual exam scores on new materials for these staff, for all topics. The submission of false or inaccurate information in reports will result in assessment of a liquidated damage of $10,000 and will entitle HHSC to terminate the agreement. HHSC will report suspected fraudulent reporting to appropriate enforcement authorities.
MTO 6	Section 2.3.11; 2.35.4;	MTP call center customer service measures (applies to all callers): • • Telephone staff must greet callers and identify themselves by first name and identification number when answering.	Maintain a monthly average score of 85% for MTP call center customer service measures, for all MTP call center calls monitored, as indicated on the MTP call center summary quality activity report.	Monthly	n/a	$1,250 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $625 for each subsequent, consecutive month that non-compliance continues. "Occurrence" is defined here as month when the average score of all MTP call center customer service standards

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						(as indicated by call monitoring sessions) drops below 85%. Example: The section(s) of MTO monitoring form for MTP call center calls that addresses the MTP call center customer service measures will yield a score, that when averaged across all MTP call center calls monitored for the month, will meet or exceed 85%, in order to be compliant. Note: Depending on the design of the MTO monitoring form, this standard may be broken out into separate standards, or may require other modification, which will be addressed during negotiations.
MTO 7	Section 2.3.12	Submit monitoring forms and monitored calls monthly pertaining to MTP eligible clients. Reports must be submitted in a media and format approved by HHSC.	Submit monitoring forms monthly pertaining to MTP eligible clients, as specified.	Monthly	n/a	$250 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $125 for each subsequent, consecutive week that non-compliance continues. "Occurrence" is defined here as each week in which the

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						MTO does not submit the monitoring forms and monitored calls as required.
MTO 8	Section 2.3.12	Monitor and evaluate staff performance for calls from MTP eligible clients to the client toll-free line for transportation services. Calls must be submitted in a media and format approved by HHSC.	Monitor and evaluate 2% of calls from MTP eligible clients, as indicated on the summary quality activity report.	Monthly	n/a	$1,250 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $625 for each subsequent, consecutive month that non-compliance continues. "Occurrence" is defined here as each month were the MTO does not monitor and evaluate a minimum of 2% of MTP eligible client calls on staff who answer calls via the client toll-free line for transportation services, as indicated on the summary quality activity report. Note: Rounding is limited to the nearest hundredth of one percent; at that point a number greater or equal to 2% must be the result in order to be considered compliant. The submission of false or inaccurate information in reports will result in assessment of a liquidated damage of $10,000 and

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						entitle HHSC to terminate the agreement. HHSC will report suspected fraudulent reporting to appropriate enforcement authorities.
MTO 9	Section 2.3.12	Submit a quality activity report monthly to HHSC pertaining to MTP eligible clients. Reports must be submitted in a media and format approved by HHSC.	Submit a quality activity report monthly pertaining to MTP eligible clients.	Monthly	n/a	$375 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $188 for each subsequent, consecutive month that non-compliance continues. "Occurrence" is defined here as each instance where the report is submitted past the specified due date. The submission of false or inaccurate information in reports will result in assessment of a liquidated damage of $10,000 and entitle HHSC to terminate the agreement. HHSC will report suspected fraudulent reporting to appropriate enforcement authorities.
MTO 10	Section 2.3.12	This standard applies from the point at which the call reaches the toll free number platform to the point at which the call is answered by a live operator. It applies to all	Monthly percentage of blocked or failed calls at point where MTO picks up call from HHSC (for client toll free line for transportation services,	Monthly	n/a	$2,500 for the first month in which the MTO fails to meet the monthly standard specified in §2.3.12 related to the client toll free line for transportation services, for

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		calls determined to be placed by callers other than from or on behalf of a child birth through 20, with Medicaid during the hours referenced in §2.3.10.1. All call attempts during this time (determined to be placed by callers other than from or on behalf of a child birth through 20 with Medicaid) are divided into the number of attempts that received a busy signal, network error or any other type of response, other than being passed to a live operator (determined to be placed by callers, other than from or on behalf of a child birth through 20, with Medicaid).	for calls other than from or on behalf of a child birth through 20, with Medicaid), will not exceed 2%.			those calls determined to be from callers other than from or on behalf of a child birth through 20 with Medicaid. Liquidated damages will continually increase by $1,250 for each subsequent, consecutive month that non-compliance continues.
MTO 11	Section 2.4	The MTO will maintain and answer a toll-free number for clients to request a return ride, if their ride is more than 15 minutes late, and for non-client issues. Calls to this toll-free number must be answered by live operators continuously as specified in Section 2.3.10.1. This number must be different from the client toll-free number for transportation services.	No failure to telecommunications related hardware and software, and no failure of staff to answer client calls to this toll free line during the hours specified.	Per occurrence	n/a	$1,000 per failure to meet the requirements for all equipment, software, trunks, routing, etc. that impact call processing or handling for all callers to the Toll Free Client Line for transportation services. Liquidated damages will continually increase by $500 for each subsequent thirty minute period, after the initial five minutes of the outage until operations are

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						fully restored. Liquidated damages will accrue only during the line's operational (business) hours. Any measureable amount of time over a minute (i.e., a second) will advance this determination into the next minute (e.g., 5 minutes and 2 seconds will be treated as 6 minutes). Example: At 10:00 AM MTO staff spills coffee on a critical server which causes this toll-free line to go down (with no redundant systems in place). If this toll-free line is operational and staff are answering calls within: • 5 minutes, the liquidated damages for this instance are $1,000. • 6 - 35 minutes, the liquidated damages for this instance are $1,500. • 36 - 65 minutes, the liquidated damages for this instance are $2,000. • 66 - 95 minutes, the liquidated damages for this instance are $2,500. • 96 - 105 minutes, the liquidated damages for this instance are $3,000, etc.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
MTO 12	Section 2.5.2	Management The MTO will assure that key personnel staff who have authority to act on a request from the HHSC designated staff, a complaint, or any other matter relating to the performance of the services is available at minimum during MTO Hours of Operation. MTO key personnel staff will respond within 1 hour of the HHSC inquiry.	100% of the MTO's Hours of Operation will be staffed by key personnel to respond to HHSC inquiries within 1 hour.	Continuous Monitoring	0 calendar days	$500 for each hour that MTO key personnel staff did not respond within 1 hour.
MTO 13	Section 2.5.2	Management The MTO will maintain the agreed upon staffing of key personnel.	100% of the MTO's key personnel be staffed as agreed upon by HHSC and the MTO (per RFP section 2.10.1, key personnel must be replaced within 90 days after vacancy of position).	Continuous Monitoring	O calendar days	$1,000 for each MTO business day that the MTO did not meet agreed upon qualified staffing requirements of key personnel or failed to receive HHSC's approval prior to hiring.
MTO 14	Section 2.5.3	MTO must notify HHSC in writing at least five (5) business days of a position becoming vacant.	Each calendar day after due date	Ongoing		$100 per day
MTO 15	Section 2.7.2	Service Assessment The MTO must adhere to and utilize the HHSC approved policy in determining the appropriate client transportation services.	100% of all services must be authorized by MTO and determined to meet the clients' needs utilizing the HHSC approved policy.	As requested by HHSC	0 calendar days	$500 per authorization of service where the MTO failed to utilize the HHSC approved policy to determine the appropriate client transportation service, not applicable to actual

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						service delivery.
MTO 16	Section 2.7.6	Service Complaints The MTO will respond to client service delivery complaints within 5 days, Ombudsman complaints within 3 days, Legislator's office complaints within 24 hours.	98% of all complaints in a calendar month will receive a response from the MTO within the performance standard timeframe.	Monthly unless accelerated by HHSC	0 calendar days	$1,000 each percentage point below 98%.
MTO 17	Section 2.7.7	Failure of MTO to show up and adequately represent HHSC at all fair hearings.	Each occurrence	Ongoing		$5,000 per occurrence
MTO 18	Section 2.10.1	Demand Response Services The MTO must maintain a current vehicle and driver roster used to provide transportation to program clients.	100% of vehicles and drivers used in the service delivery to clients will be maintained on a vehicle and driver roster. This Performance Standard excludes drivers or vehicles that HHSC and the MTO agree are not required to be included on the driver or vehicle roster, such as public transit.	Monthly unless accelerated by HHSC	3 calendar days	$2,500 for each incident where the MTO used a vehicle or driver that was not included on the roster.
MTO 19	Section 2.11.1	Customer Service Surveys The MTO must maintain a 95% client satisfaction survey result as determined by the survey conducted by the independent research organization. Corrective action plans must be submitted to HHSC if less	95% of all client surveys will indicate satisfaction with transportation services provided or arranged by MTO or its Performing Providers.	Quarterly	0 calendar days	$2,500 for each quarter that client surveys did not meet the 95% threshold.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		than 95% client satisfaction.				
MTO 20	Section 2.11.1	Customer Service Surveys The MTO must contract with an independent research organization to conduct quarterly client and medical service provider satisfaction surveys.	100% of all client surveys will be performed by an independent contractor	Quarterly	0 calendar days	$8,000 for each quarter that client surveys are not conducted by an independent organization.
MTO 21	Section 2.11.1	Customer Service Surveys The MTO must submit client survey results by the contract required timeframes.	100% of client survey results will be submitted by the timeframe specified in the Reports Table.	Quarterly	0 calendar days	$5,000 for each quarter that client surveys did not meet the contract required timeframe.
MTO 22	Section 2.12.2	Failure to comply with documentation requirements for maintaining proof of insurance	Each occurrence	Ongoing		$500 per day
MTO 23	Section 2.16 - Applicable Laws	Compliance with Laws The MTO must comply with the requirements of the laws applicable to the performance of the contract which include certain: a. state and federal regulations b. state Medicaid rules and regulations c. state regulations regarding transportation services d. Texas Administrative Code e. Corrective Action Orders and the Consent Decree *Frew* v Janek	100% compliance with Applicable Laws.	Continuous Monitoring by HHSC staff	0 calendar days	$5,000 a day when a MTO continues non-compliant actions after notification by HHSC that it is out of compliance with applicable laws.
MTO 24	Section: 2.10.2	Client Safety	100% of all persons	Continuously	0 calendar	$10,000 per accident when

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
	2.18.2; 2.18.4; 2.21; 2.22.2; 2.35.3	MTO must prepare a training plan, training materials and manuals for HHSC approval upon readiness review.	responsible for transporting clients must comply with all client safety procedures 100% of the time.		days	client injuries occurred due to failure to follow procedures in HHSC approved plans, materials and manuals. MTO will also be placed on automatic Corrective Action. Client injuries means an accident or incident where the client was injured and required medical attention or was assaulted or sexually harassed.
MTO 25	Section 2.15; 2.18.2; 2.18.3; 2.18.4; 2.22.2.4	Required MTO Plans and Manuals The MTO will adhere to the following HHSC approved plans and manuals: Inclement Weather Plan; Business Continuity and Disaster Recovery Plan; Performing Provider NEMT Manual; Operating Procedures Manual; Implementation Work Plan; Quality Assurance Plan Transition Plan	100% adherence to HHSC approved plans and manuals	Continuous Monitoring	0 calendar days	$1,500 per day for non-compliance for each plan.
MTO 26	Section 2.18.1	Performing Provider Monitoring The MTO will submit timely and complete Performing Provider monitoring reports.	100% complete monthly reports are submitted to HHSC by the required deadlines	Monthly unless accelerated or requested by HHSC	3 business days following the due date	$500 per report for each business day the report is not timely and complete (after Cure Period). A complete report contains an accurate response to each item required in the report.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
MTO 27	Section 2.18.1	Performing Provider Management The MTO must maintain documentation for 100% of its subcontracts, records specified in the Performing Provider NEMT Manual, agreements, Business Associate Agreements when applicable, required insurance coverage and enrollment information for Performing Providers listed on the MTO approved Performing Providers list at the Texas headquarters.	100% of Performing Provider records specified in the subcontract or Performing Provider NEMT Manual, agreements, Business Associate Agreements when applicable, and enrollment information for Performing Providers listed on MTO approved Performing Provider list must be at the MTO's Texas headquarters.	Continuous Monitoring	5 calendar days	$1,000 per occurrence when performance measure is not met. "Occurrence" means an agreement, record specified in the Performing Provider or NEMT Manual or enrollment information that is not on file at the MTO's Texas headquarters following the cure period.
MTO 28	Section 2.18.1	Performing Provider Monitoring The MTO will monitor all Performing Providers in accordance with all contract requirements, the Performing Provider NEMT Manual, and the approved Performing Provider Monitoring Plan. The MTO must meet oversight and monitoring requirements of all Performing Providers according to the contract requirements and approved Performing Provider Monitoring Plan.	100% of all Performing Providers are monitored according to contract requirements, the approved Performing Provider Monitoring Plan, and the Performing Provider NEMT Manual.	Continuous Monitoring	0 calendar days	$750 per requirement, per Performing Provider, per monitoring period for each monitoring performance measure not met. Supporting documentation will be required as proof that monitoring activities were performed.
MTO 29	Section 2.18.1; UTC 1.4.1.	Performing Provider Monitoring The MTO must submit	100% of all corrective action plans are submitted to HHSC by approved	Continuous Monitoring by HHSC	3 business days	$1,000 per occurrence when performance measure is not met. Occurrence means a

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		corrective action plans (CAP) by required timeframes.	timeframes or with extensions approved by HHSC			corrective action plan that is not submitted on time.
MTO 30	Section 2.18.1; UTC 1.4.1.	Performing Provider Monitoring The MTO must implement all items noted in the corrective action plan by required timeframes	100% of all items noted in HHSC approved corrective action plan must be implemented by the required timeframes	Continuous Monitoring by HHSC	0 calendar days	$1,000 per day for each item noted in corrective action plan that the MTO did not implement by timeframe required in CAP.
MTO 31	Section 2.18.1	Demand Response Services The MTO must ensure that a reliable fleet of vehicles, including ADA compliant vehicles, that meet federal, state and local ordinances, including insurance requirements are used to transport clients safely.	100% of vehicles providing services must meet performance standard requirements.	Quarterly unless accelerated by HHSC	3 calendar days	$1,000 for each vehicle when it does not meet the performance standard requirements at the time the vehicle was used to transport the client.
MTO 32	Section 2.18.1	Demand Response Services The MTO must ensure that drivers adhere to requirements in the HHSC approved Performing Provider NEMT Manual. Driver records must be kept at the Texas headquarter office and available for inspection.	100% of drivers will meet the requirements in the HHSC approved Performing Provider NEMT manual as documented by records retained by the MTO and available for inspection.	Continuous Monitoring by HHSC staff	3 calendar days	$1,000 for each driver that does not meet the requirements in HHSC approved Performing Provider NEMT manual as evidenced by records available for inspection in MTO's driver files or as noted during monitoring activities. $2,000 for unlicensed drivers or for the use of a driver prior to completing contract requirements and properly documenting criminal background checks

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						annually.
MTO 33	Section 2.18.1	Demand Response Services The MTO must ensure that records of operating equipment for each vehicle used to provide client transportation are maintained at its Texas headquarter office for inspection.	100% of contract required vehicle documentation will be on site and available for inspection.	Quarterly unless accelerated by HHSC	3 calendar days	$750 per document per HHSC request for information the MTO fails to have available on site for inspections.
MTO 34	Section 2.18.1	Demand Response Services The MTO must ensure that all demand response drivers do not charge program clients for services authorized by the MTO	100% of all Performing Provider services will be provided at no charge to clients. Upon being informed that a Performing Provider inappropriately charged a client, the MTO shall reimburse the client the charged amount within twenty-four (24) hours of being notified of the event.	As necessary	0 calendar days	$500 per incident, per day when the MTO does not reimburse the client within twenty-four (24) hours.
MTO 35	Section 2.18.2	Client Communication The MTO will provide program services and information in the appropriate language and in adherence to the Limited English Proficiency (LEP) requirement.	100% of clients will receive services and information per LEP contract requirement.	Quarterly	0 calendar days	$1,000 for each time the MTO failed to adhere to the LEP contract requirement.
MTO 36	Section 2.18.3	Quality Assurance The MTO must adhere to the HHSC approved Quality Assurance Plan	100% compliance to all HHSC approved Quality Assurance Plan items	Continuous Monitoring	3 calendar days	$1,000 for each item in the HHSC approved Quality Assurance Plan for which the MTO is found non-

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						compliant.
MTO 37	Section 2.18.3	MTO must prepare and submit an acceptable Quality Assurance Plan no later than forty-five (45) calendar days after the contract is awarded or by the date specified by HHSC.	Each calendar day after due date	One-time		$500 per day
MTO 38	Section 2.18.4	MTO must prepare and submit an acceptable Transition Plan to HHSC for acceptance and approval on the date set no later than forty-five (45) calendar days after the contract is awarded or upon a date approved by HHSC.	Within forty-five (45) calendar days after contract execution or by the date specified by HHSC.	One-time		$500 per day
MTO 39	Section 2.18.4	MTO must prepare and submit an acceptable Transition Plan no later than forty-five (45) calendar days after the contract is awarded or by the date specified by HHSC.	Each calendar day after due date	One-time		$500 per day
MTO 40	Section 2.20	MTO must prepare and submit an acceptable Comprehensive Work Plan no later than fourteen (14) business days after the contract execution.	Within fourteen (14) business days after contract execution or by the date specified by HHSC.	One-Time		$1,000 per day

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
MTO 41	Section 2.21	MTO must submit a final implementation work plan electronically or via mail no later than fourteen (14) business days after contract execution or by the date specified by HHSC.	Within fourteen (14) business days after contract execution or by the date specified by HHSC.	One-Time		$1,000 per day
MTO 42	Section 2.22.1.1	Payment Administration The MTO will promptly pay valid, undisputed Performing Provider invoices	98% of all undisputed Performing Provider invoices are paid within the terms of the agreement between the Performing Provider and the MTO. MTO will provide the documentation to support timely payment of Performing Provider.	Monthly unless accelerated by HHSC	0 calendar days	$1,000 per percentage point below 98% of all undisputed Performing Provider invoices in a calendar month when invoices are not paid according to the payment schedule agreed upon by the Performing Providers and approved by HHSC. MTO will provide the documentation to support timely payment of Performing Provider.
MTO 43	Section 2.22.2	MTO must perform monthly validation checks of Performing Provider and/or Material Subcontract claims.	Monthly	Ongoing		$100 per claim
MTO 44	Section 2.22.2	Report the required percentages in the format approved by HHSC for validation checks.	Failure to achieve and report the required percentages in the format approved by HHSC no later than thirty (30) days following payment of service	Ongoing		$100 per reporting period
MTO 45	Section 2.23.1	MTO must submit an Operational Readiness Plan no later than August 1, 2014.	Each calendar day after due date	One-Time		$5,000 per day
MTO 46	Section 2.23.2	Readiness Review	100% of all Readiness		MTO will	$6,000 for each day

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		The MTO must pass the Operational Readiness Review by the Required Timeframe	Review contract requirements are completed and approved by HHSC		have one opportunity to make corrections after the initial HHSC Operational testing. HHSC will provide date of second inspection.	following the second inspection date that the MTO is not fully operational with the option to terminate the contract award.
MTO 47	Section 2.23.3	MTO must submit a Financial Update Report to HHSC no later than sixty (60) days prior to the Operational Start Date.	Each calendar day after due date	One-Time		$5,000 per day
MTO 48	Section 2.24; 2.41	Records Management The MTO must comply with the approved HHSC recordkeeping and record retention policy.	100% compliance in meeting records management requirements. HHSC requests for documents must be received by the HHSC specified deadline.	Quarterly unless accelerated by HHSC	3 calendar days	$5,000 for each occurrence when the MTO could not produce records referenced in the Recordkeeping and Record Retention section of the contract by the HHSC specified deadline. Occurrence means each HHSC request.
MTO 49	Section 2.24; 2.25	Reporting Requirements (excluding call centers, see additional Performance Measures document for call center reporting requirements) MTO must submit complete and accurate reports as outlined by the contract.	100% compliance in submitting complete and accurate reports according to the contract reporting requirements.	According to timeframes in Attachment J Contract Required Reports.	3 calendar days	$1,000 per report per business day that report is not accurate and complete. An accurate report contains responses which represent the truth to the best of the MTO's ability. A complete report contains responses to each item required in the report.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
MTO 50	Section 2.24; 2.25	The MTO will file and submit all reports that require an immediate response according to the Reports Table.	100% of all MTO reports specified in the Reports Table that require an immediate response will be filed and submitted. "Immediate" is defined as being as soon as is reasonably possible, not to exceed three (3) hours from the time the MTO becomes aware of the triggering event.	As necessary	0 calendar days	$1,500 per incident that required an immediate response and was not reported timely.
MTO 51	Section 2.24; 2.25	Reporting Requirements (excluding call centers, see additional Performance Measures document for call center reporting requirements). The MTO must submit all required reports within the HHSC deadlines adhering to the Reports Table (Attachment J)	100% of all reports will be submitted within the required reporting timeframes.	According to timeframes in Attachment J Contract Required Reports unless accelerated by HHSC.	3 calendar days	$1,000 per report for each business day the report is not submitted after Cure Period.
MTO 52	Section 2.26	Automation Systems The MTO must assure that automation and software systems required in the contract are operational.	100% compliance to maintain the required automation and software system operational.	Monthly unless accelerated by HHSC	0 calendar days	$1,000 for every increment of 60 minutes that automation and software system is not operational during normal reservation hours. Fractional periods of non-operation will be totaled during the normal reservation hours to calculate the increment."
MTO 53	Section 2.26	MTO must submit an annual certified financial audit through the close of each MTO fiscal year as required	Within the close of each MTO fiscal year just ended.	Annually		$1,000 per day

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		pursuant to Section 6.2.1.1 and 6.17.1.				
MTO 54	Section 2.27.2.5	MTO must prepare and submit an acceptable Disaster Recovery and Business Continuity Plan within ninety (90) days prior to the Operational Start Date or by the date specified by HHSC.	Each calendar day after due date	One-time		$200 per day
MTO 55	Section 2.27.2.5	MTO must prepare and submit an acceptable Security Plan no later than ninety (90) days prior to the Operational Start Date or by the date specified by HHSC.	Each business day after due date	One-time		$1,000 per day
MTO 56	Section 2.27.3	MTO must prepare and submit an acceptable Annual Disaster Recovery and Business Continuity Plan at the beginning of each State Fiscal Year.	Each calendar day after due date	Annually		$200 per day
MTO 57	Section 2.27.3.2.3	MTO must prepare and submit an annual acceptable Systems Quality Assurance Plan at the beginning of each State Fiscal Year.	Each calendar day after due date	Annually		$500 per day
MTO 58	Section 2.29.1.2	MTO must submit complete and accurate Encounter Data at least monthly.	Failure to submit complete and accurate Encounter Data at least monthly, but not later than the 30th calendar day after the last day of the month in which each claim was adjudicated.	Monthly		$500 per day
MTO 59	Section 2.35	Maintain all telecommunications related	No failure to telecommunications	Daily	n/a	$1,000 per failure to meet the requirements for all

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		hardware and software, on an ongoing basis, that supports or impacts calls from or on behalf of a child birth through 20 with Medicaid, to support all requirements in §2.35.	related hardware and software, during business hours.			equipment, software, trunks, routing, etc. that impact call processing or handling for callers, from or on behalf of a child birth through 20 with Medicaid, to the Toll Free Client Line for transportation services. Liquidated damages will continually increase by $1,000 for each subsequent thirty minute period, after the initial five minutes of the outage until operations are fully restored. Liquidated damages will accrue only during the line's operational (business) hours. Any measureable amount of time over a minute (i.e., a second) will advance this determination into the next minute (e.g., 5 minutes and 2 seconds will be treated as 6 minutes). Example: At 10:00 AM MTO staff spills coffee on a critical server which causes the MTO ACD reporting system to fail (with no redundant systems in place). If MTO systems are back on line within: • 5 minutes, the liquidated

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						damages for this instance are $1,000. • 6 - 35 minutes, the liquidated damages for this instance are $2,000. • 36 - 65 minutes, the liquidated damages for this instance are $3,000. • 66 - 95 minutes, the liquidated damages for this instance are $4,000. • 96 - 105 minutes, the liquidated damages for this instance are $4,000, etc.
MTO 60	Section 2.35.3	The MTO's monthly report will include individual exam scores on new materials for MTO staff who answered calls, from or on behalf of a child birth through 20, with Medicaid for the prior month. "New materials" include training for new staff or training of existing staff on new or updated materials. MTO staff who do not achieve the minimum required score for each exam on new materials, must not answer calls, from or on behalf of a child birth through 20, with Medicaid, until the required scores are achieved,	For staff answering calls, from or on behalf of a child birth through 20, with Medicaid, each individual must achieve a minimum score of 85% or better on all new material exams.	Each month in which staff answers calls, from or on behalf of a child birth through 20, with Medicaid.	n/a	$500 for each occurrence. "Occurrence" is defined here as each new material exam score below 85% (the most recent exam on the topic) per staff who answered calls, from or on behalf of a child birth through 20, with Medicaid, during the month. It is not required that all MTO staff meet the 85% on the first try. Individuals failing to meet or exceed that minimum must not answer calls from or on behalf of a child birth through 20, with Medicaid until they are re-tested and able to achieve a score of 85% or better.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		via re-test. MTO must submit and certify the summary testing report to HHSC by the 2nd business day of the month following any month in which MTO staff answers calls, from or on behalf of a child birth through 20, with Medicaid. The monthly report must be submitted in a media and format approved by HHSC.				Exam questions for staff being re-tested must be sufficiently different, to discourage memorization of the previous exam answers. Liquidated damages will continually increase by $250 (per exam, per staff) for each subsequent, consecutive month that non-compliance continues, for that particular MTO staff. Example: the MTO new hire training are comprised of 10 exams. MTO Agent A scores 85% or better on 8 of those exams and 70% on the remaining two exams. If MTO Agent A answers calls, from or on behalf of a child birth through 20, with Medicaid, during the month, liquidated damages of $1,000 are due (two exam scores below 85%). However, if MTO Agent A re-takes the two exams in question and eventually achieves 85% or greater on both of them before answering calls , from or on behalf of a child birth through 20, with Medicaid, no liquidated damages are

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						due for this measure for Agent A. "Re-test" is defined as a subsequent attempt to achieve the required score by an individual, on a test, per topic. Note that re-test is different from re-training (see definition of re-training below). The monthly summary testing report will indicate the MTO staff who answered calls, from or on behalf of a child birth through 20, with Medicaid, for the prior month and the most recent individual exam scores on new materials for these staff, for all topics. The submission of false or inaccurate information in reports will result in assessment of a liquidated damage of $20,000 and will entitle HHSC to terminate the agreement. HHSC will report suspected fraudulent reporting to appropriate enforcement authorities.
MTO 62	Section 2.35.3	The MTO's monthly report will include individual exam	Individual scores of 90% or better on all re-training	Each month in which staff	n/a	$500 for each occurrence.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		scores on re-training for MTO staff who answered calls from or on behalf of a child birth through 20 with Medicaid, for the prior month. "Re-training" shall include those staff, that call monitoring indicates a need for re-training. MTO staff who do not achieve the minimum required score for each re-training exam, must not answer calls, from or on behalf of a child birth through 20, with Medicaid, until the required scores are achieved, via re-test. MTO must submit and certify summary testing report to HHSC by the 2nd business day of the month following any month in which MTO staff answers calls, from or on behalf of a child birth through 20, with Medicaid. The monthly report must be submitted in a media and format approved by HHSC.	exams, for staff who answer calls, from or on behalf of a child birth through 20, with Medicaid, each month.	answers calls, from or on behalf of a child birth through 20, with Medicaid.		"Occurrence" is defined here as each re-training exam score below 90% (the most recent exam on the topic) per staff who answered calls, from or on behalf of a child birth through 20, with Medicaid, during the month. It is not required that all MTO staff meets the 90% on the first try. Individuals failing to meet or exceed that minimum must not answer calls, from or on behalf of a child birth through 20, with Medicaid, until they are re-tested and able to achieve a score of 90% or better. Exam questions for staff being re-tested must be sufficiently different, to discourage memorization of the previous exam answers. Liquidated damages will continually increase by $250 (per exam, per staff) for each subsequent, consecutive month that non-compliance continues, for that particular MTO staff. Example: the MTO new hire training are comprised of 10 exams. Call monitoring of

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						MTO Agent B indicates that re-training is required on one of these 10 areas. If MTO Agent B answers calls, from or on behalf of a child birth through 20, with Medicaid, during the month, after the determination that re-training is required, without have re-trained, taken the appropriate exam and achieved the required score, liquidated damages of $500 are due (one exam, no score yet as re-training has yet to occur). However, if MTO Agent B completes re-training and eventually achieves 90% or greater on the exam before answering calls, from or on behalf of a child birth through 20, with Medicaid, no liquidated damages are due for this measure for Agent. The monthly summary testing report will indicate the MTO staff who answered calls, from or on behalf of a child birth through 20, with Medicaid, for the prior month and the most recent individual exam scores on re-training for these staff, for all topics.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						The submission of false or inaccurate information in reports will result in assessment of a liquidated damage of $20,000 and entitle HHSC to terminate the agreement. HHSC will report suspected fraudulent reporting to appropriate enforcement authorities.
MTO 63	Section 2.35.4	For calls determined to be placed by callers, from or on behalf of a child birth through 20, with Medicaid, during hours referenced in Section 2.3.10.1 the MTO will record all answered calls, from or on behalf of a child birth through 20, with Medicaid, in their entirety.	Record 100% of all calls placed from or on behalf of a child birth through 20, with Medicaid.	Monthly	n/a	$500 for each occurrence that violates the recording standard specified in §2.35.4 related to the client toll free line for transportation services, for those calls determined to be from or on behalf of a child birth through 20, with Medicaid. This amount is capped at $5,000 per day. "Occurrence" is defined here as each call, from or on behalf of a child birth through 20, with Medicaid, answered by a live Agent, that is either not completely recorded or where the recording is not produced upon request. Liquidated damages will continually increase by $250 per occurrence for each

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						subsequent day in which there are additional occurrences. The amount only resets back to the original $500 per occurrence if the MTO has no violations of this standard for 3 consecutive months. <u>Example:</u> On Day 7, the MTO has an equipment failure that prevents 100 calls, from or on behalf of a child birth through 20, with Medicaid, from being recorded; liquidated damages for Day 7 are $5,000; $5,000 daily cap for this performance measure. Subsequently, on Day 16, MTO fails to record a single call, from or on behalf of a child birth through 20, with Medicaid; liquidated damages for Day 16 are $750. The per occurrence damages are $750, based on Day 16 being a subsequent day in which there was an additional occurrence (without three consecutive months of compliance between them).Total liquidated damages for this month for this performance measure

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						are $5,750. Subsequently, on Day 2 of the following month, MTO fails to record 4 calls, from or on behalf of a child birth through 20, with Medicaid; liquidated damages for Day 2 of this month are $4,000. The per occurrence damages are $1,000, based on the following progression: • $500 (1st occurrence was on Day 7 of the prior month), • $750 (2nd occurrence was on Day 16 of the prior month,), and • $1,000 (3rd occurrence was on Day 2 of the current month. • None of the three occurrences have three months of compliance between them. $1,000 times the four calls that were not recorded on Day 2 of the second month equals $4,000.
MTO 64	Section 2.35.4	Monitor and evaluate staff performance for calls from or on behalf of a child birth through 20, with Medicaid to the client toll-free line for	Monitor and evaluate 4% of calls from or on behalf of a child birth through 20, with Medicaid, as indicated on the summary	Monthly	n/a	$2,500 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $1,250 for each

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		transportation services. Calls must be submitted in a media and format approved by HHSC.	quality activity report.			subsequent, consecutive month that non-compliance continues. "Occurrence" is defined here as each month in which the MTO does not monitor and evaluate a minimum of 4% of calls from or on behalf of a child birth through 20, with Medicaid on staff who answer calls from or on behalf of a child birth through 20, with Medicaid via the client toll-free line for transportation services, or staff that answer calls from or on behalf of a child birth through 20, with Medicaid that may be transferred, as part of the normal process flow, as indicated on the summary quality activity report. Note: Rounding is limited to the nearest hundredth of one percent; at that point a number greater or equal to 4% must be the result in order to be considered compliant. The submission of false or inaccurate information in reports will result in

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						assessment of a liquidated damage of $20,000 and entitle HHSC to terminate the agreement. HHSC will report suspected fraudulent reporting to appropriate enforcement authorities.
MTO 65	Section 2.35.4	Submit monitoring forms and monitored calls weekly for calls from or on behalf of a child birth through 20, with Medicaid (see Sections 2.3.10; 2.3.10.1) Reports must be submitted in a media and format approved by HHSC.	Submit weekly, as specified	Weekly	n/a	$500 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $250 for each subsequent, consecutive week that non-compliance continues. "Occurrence" is defined here as each week in which the MTO does not submit the monitoring forms and monitored calls from or on behalf of a child birth through 20 with Medicaid, as required.
MTO 66	Section 2.35.4	Submit summary quality activity report monthly to HHSC (see Sections 2.3.10; 2.3.10.1; 2.35.12) Reports must be submitted in a media and format approved by HHSC.	Submit summary quality activity report monthly, as specified.	Monthly	n/a	$750 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $375 for each subsequent, consecutive month that non-compliance continues. "Occurrence" is defined here as each instance where the report is submitted past the

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						specified due date. The submission of false or inaccurate information in reports will result in assessment of a liquidated damage of $20,000 and entitle HHSC to terminate the agreement. HHSC will report suspected fraudulent reporting to appropriate enforcement authorities.
MTO 67	Section 2.35.4	Customer service measures for calls from or on behalf of a child birth through 20, with Medicaid: • Staff are helpful and polite, irrespective of callers' telephone demeanor; • Staff interactions with callers demonstrate needs of HHSC clients; and • Staff are trained to deal with callers who are angry, threatening, or abusive.	Maintain a monthly average score of 87% for customer service measures for all calls, from or on behalf of a child birth through 20 with Medicaid, monitored, as indicated on the summary quality activity report.	Monthly	n/a	$2,500 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $1,250 for each subsequent, consecutive month that non-compliance continues. "Occurrence" is defined here as month when the average score of all customer service standards for calls from or on behalf of a child birth through 20 with Medicaid (as indicated by call monitoring sessions) drops below 87%. Example: The section(s) of MTO monitoring form for calls, from or on behalf of a child birth through 20, with Medicaid, that addresses the

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						customer service measures for calls from or on behalf of a child birth through 20 with Medicaid will yield a score, that when averaged across all calls, from or on behalf of a child birth through 20, with Medicaid, monitored for the month, will meet or exceed 87%, in order to be compliant. Note: Depending on the design of the MTO monitoring form, this standard may be broken out into three separate standards, one for each component of the customer service standards for calls from or on behalf of a child birth through 20 with Medicaid, or the MTO monitoring form may require other modification, which will be addressed during negotiations.
MTO 68	Section 2.35.4	Customer service measures for calls from or on behalf of a child birth through 20 with Medicaid: • Staff are helpful and polite, irrespective of callers' telephone demeanor;	Correct 100% of deficiencies in customer service standards within 30 calendar days, as indicated on the summary quality activity report.	Monthly	n/a	$250 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $125 for each subsequent, consecutive occurrence of non-compliance.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		• Staff interactions with callers demonstrate needs of HHSC clients; and • Staff are trained to deal with callers who are angry, threatening, or abusive. When deficiencies in these standards are noted in call monitoring, they will be corrected (via coaching, counseling or re-training), within 30 calendar days.				"Occurrence" is defined here as each time a deficiency was noted, but not corrected within 30 calendar days and the agent continued to answer calls, from or on behalf of a child birth through 20, with Medicaid. Note that there could be multiple failures, per staff, resulting from a single monitoring session. Example: MTO Agent A is monitored on Day 14 of Month 1 and demonstrates three deficiencies in the customer service standards for calls from or on behalf of a child birth through 20 with Medicaid. MTO must coach, counsel or re-train (or otherwise appropriately address these deficiencies) within 30 calendar days. If none of the deficiencies are addressed within 30 days, and Agent A continued to answer calls, from or on behalf of a child birth through 20, with Medicaid, the liquidated damages are $750 for Agent A for this measure, for the month. If another 30 days pass and only two of the deficiencies

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						are addressed and Agent A continues to answer calls, from or on behalf of a child birth through 20, with Medicaid, the liquidated damages are $375 for Agent A for this measure, for that month ($250 plus $125). As the 30 day period to correct deficiencies may not always coincide with calendar months, MTO should include a section on the summary quality activity report, showing outstanding deficiencies where the 30 day period will carry forward into the next calendar month. Note: Depending on the design of the MTO monitoring form, this standard may be broken out into three separate standards, one for each component of the customer service standards for calls from or on behalf of a child birth through 20 with Medicaid, or the MTO monitoring form may require other modification, which will be addressed during negotiations.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
MTO 69	Section 2.36	The monthly average maximum wait (before answered by a live person), inclusive of all IVR time, for calls from or on behalf of a child birth through 20 with Medicaid. This measure is calculated as follows: 1. The MTO must track the length of the call that had the longest wait prior to speaking to a live person, each day. 2. The wait time includes all time spent in the IVR (or auto-attendant) as well as the time waiting in queue. 3. The length of each daily call with the longest wait, prior to speaking to a live person for the month will be combined and divided by the total number of business days in the month. 4. The resulting number must not exceed 300 seconds.	Monthly average maximum wait of 300 seconds, or less, for calls from or on behalf of a child birth through 20 with Medicaid.	Monthly	n/a	$5,000 for the first month in which the average maximum wait times fail to meet the monthly standard specified in §2.36 related to the client toll free line for transportation services, for those calls determined to be from callers from or on behalf of a child birth through 20 with Medicaid. Liquidated damages will continually increase by $2,500 for each subsequent, consecutive month that non-compliance continues.
MTO 70	Section 2.37	The average monthly wait to speak to a live person after the IVR message and conclusion of user selection of menu items, for calls from or on behalf of a child birth	Monthly average speed of answer to a live agent will not exceed 60 seconds, for calls from or on behalf of a child birth through 20 with	Monthly	n/a	$5,000 for the first month in which the average monthly wait to speak to a live person fails to meet the monthly standard specified in §2.35.12 related to the client

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		through 20 with Medicaid. This measure is derived by dividing the total monthly time in queue for these calls (placed by callers, from or on behalf of a child birth through 20, with Medicaid), by the number of answered calls for the month (placed by callers, from or on behalf of a child birth through 20, with Medicaid), during the hours specified in §2.3.10.1.	Medicaid.			toll free line for transportation services, for those calls determined to be from or on behalf of a child birth through 20 with Medicaid. Liquidated damages will continually increase by $2,500 for each subsequent, consecutive month that non-compliance continues.
MTO 71	Section 2.38	The number of calls that abandon, after conclusion of any IVR (or auto-attendant) selections, determined to be placed by callers, from or on behalf of a child birth through 20, with Medicaid, during hours referenced in §2.3.10.1 This measure is determined as follows: The percentage of calls received from callers, from or on behalf of a child birth through 20, with Medicaid, during each month that are abandoned, after conclusion of any IVR (or auto-attendant) selections, determined to be placed by callers, from or on behalf of a	Monthly abandon rate will not exceed 10%, for calls from or on behalf of a child birth through 20 with Medicaid.	Monthly	n/a	$5,000 for the first month in which the MTO fails to meet the monthly standard specified in §2.35.12 related to the client toll free line for transportation services, for those calls determined to be from or on behalf of a child birth through 20 with Medicaid. Liquidated damages will continually increase by $2,500 for each subsequent, consecutive month that non-compliance continues.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		child birth through 20, with Medicaid, during hours referenced in §2.3.10.1. The monthly total for this measure is divided into the monthly total calls received, after conclusion of any IVR (or auto-attendant) selections, determined to be placed by callers, from or on behalf of a child birth through 20, with Medicaid, during hours referenced in §2.3.10.1.				
MTO 72	Section 2.39	At the point where the call reaches the toll free line for transportation services, only 2% of calls can receive a busy signal, network error or any other type of response, other than being passed to a live operator, for calls determined to be placed by callers, from or on behalf of a child birth through 20, with Medicaid, during hours referenced in §2.3.10.1 this standard applies. This measure is determined as follows: This standard applies from the point at which the call reaches the toll free number platform to the point at which the call is answered by a live	Monthly percentage of blocked or failed calls at point where the call reaches the toll free line for transportation services, for calls from or on behalf of a child birth through 20 with Medicaid, will not exceed 2%.	Monthly	n/a	$5,000 for the first month in which the MTO fails to meet the monthly standard specified in §2.39 related to the client toll free line for transportation services, for those calls determined to be from or on behalf of a child birth through 20 with Medicaid. Liquidated damages will continually increase by $2,500 for each subsequent, consecutive month that non-compliance continues.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		operator. It applies to all calls determined to be placed by callers, from or on behalf of a child birth through 20, with Medicaid, during the hours referenced in §2.3.10.1. All call attempts during this time (determined to be placed by callers, from or on behalf of a child birth through 20, with Medicaid) are divided into the number of attempts that received a busy signal, network error or any other type of response, other than being passed to a live operator (determined to be placed by callers, from or on behalf of a child birth through 20, with Medicaid).				
MTO 73	Section 2.40 2.35.12	For calls determined to be placed by callers, from or on behalf of a child birth through 20, with Medicaid, during hours referenced in §2.3.10.1, staff (or equipment) are prohibited from answering a call and subsequently 1) asking callers to call back later, 2) informing caller that staff will contact them later, 3) disconnecting the call, or 4) taking some other similar action to shorten the call, short of scheduling the services requested.	No call from or on behalf of a child birth through 20 with Medicaid can be answered by asking caller to: 1. call back later, 2. informing caller that staff cannot help them now, but that staff will contact them later, 3. disconnecting call, 4. taking other action to shorten call, other than scheduling requested services.	Monthly	n/a	$1,000 for each occurrence that violates the standard specified in §2.40 related to the client toll free line for transportation services, for those calls determined to be from or on behalf of a child birth through 20 with Medicaid. Liquidated damages will continually increase by $500 for each subsequent occurrence (either in the same monthly reporting period or in subsequent

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						months). However, full compliance for three (3) consecutive months will reset the initial damage at $1,000. "Occurrence" is defined here as each instance where one of the items listed (items 1-4) occurs. If they are reported or subsequently discovered to occur 4 times in one day, that equals four occurrences. It is possible to have multiple occurrences per day.
MTO 74	Section 2.40.1	For calls determined to be placed by callers, from or on behalf of a child birth through 20, with Medicaid, during hours referenced in §2.3.10.1, staff failures to transfer calls to THSteps, as specified.	At no time can MTO staff fail to transfer callers, from or on behalf of a child birth through 20, with Medicaid, to THSteps, for scheduling assistance when clients indicate that assistance is needed.	Monthly	n/a	$500 for each occurrence that violates the standard specified in §2.35.10 related to the client toll free line for transportation services, for those calls determined to be from or on behalf of a child birth through 20 with Medicaid. "Occurrence" is defined here as each instance where it is either reported or subsequently discovered that MTO staff failed to transfer calls to THSteps, when required, for call determined to be placed by a caller, from or on behalf of a child birth through 20, with Medicaid.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						This standard is limited to one instance per call. If these occur on four different calls in one day, that equals four occurrences. It is possible to have multiple occurrences per day. Liquidated damages will continually increase by $250 for each subsequent occurrence, in a single month.
MTO 75	Section 2.3.10; 2.35.2	The client toll-free line for transportation services will be answered by live operators continuously during the hours specified in §2.3.10.1 Monday through Friday (excluding approved holidays).	No down time in answering of client calls to the toll-free line for transportation services by MTO staff, during business hours.	Per occurrence	n/a	$10,000 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $5,000 for each subsequent consecutive occurrence. $500 per failure of live operators to answer calls from all callers to the Toll Free Client Line for transportation services. Liquidated damages will continually increase by $500 for each subsequent thirty minute period, after the initial five minutes that calls are not answered until normal answering of calls resumes. Liquidated damages will accrue only

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						during the line's operational (business) hours. Any measureable amount of time over a minute (i.e., a second) will advance this determination into the next minute (e.g., 5 minutes and 2 seconds will be treated as 6 minutes). Example: At 10:00 AM MTO staff are called out of their location for a fire drill, (with no redundant staff or alternate location in place). If MTO continues to answer calls within: • 5 minutes, the liquidated damages for this instance are $500. • 6 - 35 minutes, the liquidated damages for this instance are $1,000. • 36 - 65 minutes, the liquidated damages for this instance are $1,500. • 66 - 95 minutes, the liquidated damages for this instance are $2,000. • 96 - 105 minutes, the liquidated damages for this instance are $2,500, etc.
MTO 76	General Requirement:	MTO must submit complete and accurate responses to any State Action Request (SAR)	Each calendar day for each instance of late, unacceptable or no	Ongoing		$500 per day

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
	State Action Request	memos no later than the date specified in the request.	response.			
MTO 77	General Requirement: State Action Request Extensions	MTO must submit written request for extension of a State Action Request (SAR) deadline that specifies the estimated date of completion and reasons for the extension no later than three (3) business days prior to the due date indicated in the SAR.	Each business day for each instance of late request for extension.	Ongoing		$500 per day
MTO 78	General Requirement: Failure to Perform an Administrative Service Contract	The MTO fails to timely perform an MTO Administrative Service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, such failure either: (1) results in actual harm to a Member or places a Member at risk of imminent harm, or (2) materially affects HHSC's ability to administer the Program(s).	Each calendar day of non-compliance	Ongoing		HHSC may assess up to $7,500.00 per day for each incident of non-compliance.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
MTO 79	General Requirement: Failure to Provide a transportation service Contract	The MTO fails to timely provide a transportation service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, such failure results in actual harm to a Member or places a Member at risk of imminent harm.	Each calendar day of non-compliance	Ongoing		HHSC may assess up to $7,500.00 per day for each incident of non-compliance.
MTO 80	General Requirement:	The Parties agree that HHSC may assess a liquidated damage of up to $500 per calendar day for each instance of MTO's breach or nonperformance of a duty that is not specified in the Key Performance Requirements.	MTO must perform all duties required under the Contract.	Ongoing		$500 per calendar day for each instance of MTO's breach or nonperformance of a duty not specified in the Key Performance Requirements, after HHSC has given notice to MTO of such non-performance.

MTO Joint Interface Plan

Created By:

Deliverable Owner:

Original Date Prepared:

Revision Date:

Version:

Revision History

Date of Revision	*Revision Made By*	*Version Number*

Revisions

Date	Details of change

Table of Contents

1.0 INTRODUCTION

MTO Contact Information

Name
Title
Phone number
Email address

Interface Partner Information

Partner	Description	Contact Person	Phone Number

Overview of JIP Details

File layout format::

Field # or Field Location (start and end)	Field Name	Field Type	Field Size	Field Value	Field Description/Details

File Naming Conventions:

File Name ID Table for MTO Interfaces

FILE ID	DESCRIPTION	Program	SENDER	RECEIVER	FREQUENCY	ASSOCIATED FILE ID #

2.0 FILES SENT BY THE MTO

The following describes the files sent by the MTO.

2.1. To Claims Administrator:

Filename

Description and Purpose:

Frequency:

Submitted to:

Field # or Location (start and end)	Field Name	Field Type	Field Size	Value	Description

2.2 To State:

Filename

Description and Purpose:

Frequency and Criteria:

Submitted to:

Field # or Location (start and end)	Field Name	Field Type	Field Size	Value	Description

2.3 To Others:

Filename

Description and Purpose:

Frequency and Criteria:

Submitted to:

Field # or Location (start and end)	Field Name	Field Type	Field Size	Value	Description

3.0 FILES RECEIVED BY THE MTO

The following describes the files received by the MTO.

3.2 From Claims Administrator:

Filename

Description and Purpose:

Frequency:

Submitted to:

Field # or Location (start and end)	Field Name	Field Type	Field Size	Value	Description

3.3 From State:

Filename

Purpose:

Frequency:

Submitted to:

Field # or Location (start and end)	Field Name	Field Type	Field Size	Value	Description

3.4 From Others:

Filename

Purpose:

Frequency:

Submitted to:

Field # or Location (start and end)	Field Name	Field Type	Field Size	Value	Description

ENCOUNTER DATA

This information is only an example of fields that may be required to be reported in the encounter file. Some components may change. Updated information will be available in the procurement library as they are developed.

Managed Transportation Organizations (MTO) are organizations that deliver transportation services to Medical Transportation Program (MTP) eligible clients. The entity assumes full financial responsibility to provide all covered services for eligible members at the capitation rate. The MTO is reimbursed based on the per Medicaid enrollee per member per month payment reimbursement methodology. The MTO will be responsible for reporting encounter data to HHSC or its designee by submitting a monthly aggregate file of paid claims.

The following is minimum information each encounter file will need to contain for reporting purposes:

- Encounters file will be equal to or less than 5000 transactions
- Encounters Interface file will be sent a minimum of once a month
- The naming convention for the Encounter file (837P) retrieved from the TxMedCentral
- HIPAA edits will apply to Enc files
- **999999999** must be entered in the PCN field on the 837P encounter file for MTO clients who do not have a Medicaid PCN
- The MTO should appear as the billing provider on encounter file
- The subcontractor should appear as the performing provider on the encounter file
- Subscriber's Texas Medicaid assigned Primary Member Identification Number (Patient Control Number) must be present in 2010BA - NM109
- Subscriber Last Name must be present in 2010BA - NM103
- Subscriber First Name must be present in 2010BA - NM104
- Non Person Entity must be present in 2010AA - NM 103 with Entity Type Qualifier '2' in NM102
- Provider NPI must be present in 2010AA - NM109 when available
- Provider Tax ID must be present in 2010AA - REF02 with qualifier EI in REF01 when SSN is not available
- Provider SSN must be present in 2010AA - REF02 with qualifier SY in REF01 when Tax ID is not available
- Provider API must be present in 2010BB - REF02 with qualifier G2 in REF01 when NPI is not available
- From Date of Service in 2400-DTP03 must be contained in the Enc file
- To Date of Service must be present in 2400-DTP03
- Procedure Code must be present in 2400-SV101-2
- Cost of Service (Total Payer/MTO Paid Amount) must be present in 2320-AMT02
- ICN with a leading sequence number must be present in 2330B-REF02
- The value of the claim adjustment ICN with a leading sequence number must be present in 2300-REF02
- The value of the Claim Adjustment Group Code must be present in 2320-CAS01

- The value of the Claim Adjustment Reason Code must be present in 2320-CAS02 (05, 08, 11, 14, 17)
- The value of the Claim Adjustment Amount must be present in 2320-CAS03 (06, 09, 12, 15, 18)

Attachment K –Cost Principles for Expenses

Applicability of the Cost Principles for Expenses

This document is part of the Contract, and applies to Managed Transportation Organizations (MTOs) participating in the HHSC Medical Transportation Program (MTP) for nonemergency medical transportation under Medicaid. It also applies to any other Texas Medicaid or CHIP capitated full-risk contract that may reference these specific Cost Principles. Certain other HHSC Programs have different versions of the Cost Principles that apply specifically to the given Program. The differences may be significant in places.

I. General

A. Introduction

This document, Cost Principles for Expenses, contains principles establishing the allowability or unallowability of administrative expenses, reinsurance expenses, subcontract expenses, medical transportation owned-fleet operating expenses, and other expenses relative to the Managed Transportation Program (MTP) Financial Statistical Reports (FSRs). The allowability or unallowability of expenses impact the calculation of FSR-reported net income, and consequently may affect the experience rebate calculated in accordance with the Contract's requirements. These principles apply to both direct and indirect costs. A cost is allowable only to the extent of benefits received by HHSC under the Contract, and to the extent that the cost conforms to the policies, principles, and requirements of these Cost Principles.

All costs reported by MTOs on the FSR are subject to the cost allowability requirements under these Cost Principles. Until audits are completed on 120-day FSRs (and any corresponding adjustments are made to FSRs), amounts are subject to revision by HHSC for appropriate reporting on the FSR, according to the Cost Principles. This may in turn impact calculations or payments for Experience Rebates on prior periods.

B. Relevance of the Federal Acquisition Regulations (FAR) and Office of Management and Budget Circular A-122 (OMB A-122)

All costs, fees, assessments, Affiliate transactions, and Subcontracts are subject to the allowability tests and requirements as set forth in the FAR (48 C.F.R Part 31) and OMB Circular A-122, except where HHSC specifically allows an exception as documented in this the Cost Principles or other Contract language. Any such exception must be specifically noted as an exception to FAR or OMB A-122. In case of any conflicts between the Contract and any language from FAR, OMB A-122, or Generally Accepted Accounting Principles (GAAP), the Contract prevails. If there is a conflict between the principles, regulations, or requirements of GAAP versus those of FAR or OMB A-122, then FAR or OMB A-122 prevails.

Regulatory language involving a CMS exemption of applicability of FAR or OMB Circulars to Medicare will not overrule the Cost Principles.

For purposes of applying FAR to the MTO Contract, "at risk" contracts (such as Medicaid/CHIP capitation arrangements) will be Fixed Price contracts in FAR terminology, whenever FAR distinguishes between Fixed Price and Cost Reimbursement contracts.

C. 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 MTOs for these same expenses or costs, even if the state did not previously disallow those expenses. Going forward, the state would deem any similar expenses or costs unallowable. If the state retroactively recoups money from the MTOs due to a federal disallowance, the state will recoup the entire amount paid to the MTO for the federally disallowed expenses or costs, not just the federal portion.

D. Affiliate transactions and Affiliate cost reporting

The requirements of the Cost Principles prevail over all FAR, OMB A-122, GAAP, and any other regulatory or Contract language regarding "fair and equitable," "reasonable," or similar terms that refer to pricing between Affiliates.

For FSR reporting, profits made by an Affiliate due to the MTO's Contract must be attributed as profits to the MTO Contract, even if the profits are reasonable. Narrowly-defined exceptions to this rule are identified in Section I(D)(3), "Exceptions to Affiliate cost-based reporting." Affiliates may make profits on the MTO Contract, but they must be labeled and reported to HHSC accordingly by the MTO, and not converted to an MTO "cost" for FSR reporting purposes.

For FSR reporting, fees paid by an MTO to an Affiliate are allowable only at the Affiliate's actual cost, except as described in Section I(D)(3), below.

(1) FSR reporting requirements for Subcontractors, including Affiliates. Terms of the MTO Contract apply to any MTO Subcontracts. Consistent with the MTO's affirmative duty to not include its own unallowable costs in FSR reporting, the MTO is responsible for segregating any unallowable Affiliate costs for FSR reporting purposes. The "full cost" from an Affiliate does not generally include Affiliate profit labeled as an MTO cost. Costs incurred by affiliated Subcontractors are subject to the same allowability tests as the MTO's costs, and therefore, may be disallowed for FSR reporting purposes.

HHSC's right to obtain and review financial and cost documents extends to Subcontractors, including the right to: (1) examine supporting documentation for cost build-up in Affiliate Subcontracts; (2) review a Subcontractor's income statement; and (3) segregate, within the income statement, certain revenue and cost categories by those attributable to the MTO Contract versus all other revenues and costs. At

HHSC's direction, the MTO may be required to file a separate FSR for an affiliated Subcontractor. Any findings by HHSC or its auditors will not affect the Affiliate's books, records, or financial reporting; findings would only apply to the MTO's FSR reporting.

(2) Subcontract submission/notification: relevance to cost reporting allowability rules. HHSC's review of a Subcontract or Affiliate agreement will not be construed as a determination that a cost or expense is allowable under state or federal laws, rules, or regulations, or the requirements of the MTO Contract, including the Cost Principles. Subcontracts are not exempt from audit and must conform to the Cost Principles.

Any approval of a Subcontract or Affiliate agreement by a regulatory agency other than HHSC does not overrule the terms of the MTO Contract. Thus, any approval of costs or transaction types by the Texas Department of Insurance (TDI) may be applied to the MTO's reporting to and compliance with TDI requirements, but does not provide exemption from the Cost Principles.

(3) Exceptions to Affiliate cost-based reporting. An exception to the rule regarding Affiliate cost reporting occurs when an Affiliate has routine sales to multiple unaffiliated third parties, selling standard items or services ("Comparable Unaffiliated Sales"). In these cases, external prices for interchangeable items or specific services would be comparable.

This exception does not apply to parental administrative services agreements or Affiliate reinsurance.

Use of the Comparable Unaffiliated Sales exception in FSR reporting of Affiliate costs must receive HHSC's prior written approval, but approval does not exempt the approach from audit. To request the Comparable Unaffiliated Sales exception for FSR reporting, the MTO should submit supporting documentation to HHSC, such as names of specific unaffiliated entities that are sold to, prices to each, timeframe, and the comparability of the services being sold and priced. To make a determination, HHSC or its designee may require the MTO to submit information regarding sales classifications and price lists or contracts documenting pricing details. Provider Contracts do not require application or written approval for pricing.

In contrast to the exception for Comparable Unaffiliated Sales, in most cases, an invoking of the general concept of "fair market value" or being "market priced" will not overrule the requirements regarding reporting Affiliate costs on the FSR at only the Affiliate's actual cost. Fair market value will only apply to goods or services that meet all the following criteria: 1) standardized, equivalent, easily measurable, and comparable; 2) bought and sold widely, by numerous unrelated third-party buyers and multiple unrelated third-party sellers; and 3) have a readily available independent source for comparative market pricing data. Similarly, "commercial item status" will only apply to items that are readily available to buyers off-the-shelf, with easily discernible prices. The above would require situations where there are directly comparable services that are provided and sold to multiple unaffiliated third parties, and wherein the price, terms, and details of service in these third-party transactions are readily apparent (or can be provided to HHSC's satisfaction).

If an MTO has Affiliate costs that it believes meet the criteria stated herein of either fair market value or commercial item status, it must receive HHSC's prior written consent prior to FSR submission. The burden is on the MTO to demonstrate to HHSC that the Affiliate costs meet the criteria. It is not the responsibility of HHSC or its auditor to develop a market comparison analysis or to independently verify in any other way that the criteria are met.

Conducting studies (by third-party experts or otherwise) to determine an "industry range" of a percentage of premiums to assess for corporate overhead and services, or being "within market standards" or "based on prevailing market terms" for pricing, etc., does not provide valid grounds to include in the FSR an Affiliate fee assessment in excess of the actual costs incurred by the Affiliate.

(4) Affiliate vs. unaffiliated third party Subcontracts. MTOs may contract with Affiliates for various services in order to take advantage of economies of scale, potentially superior capabilities, and for other possible advantages or reasons. If the MTO procures services outside of unaffiliated, true arm's-length situations, additional efforts by the MTO may be required to demonstrate allowability.

Amounts paid to affiliated Subcontractors for goods and services rendered may not be allowable for FSR reporting purposes if they do not fall under an allowable category. MTO costs that are unallowable in terms of FSR reporting may not become an allowable deduction against reported FSR profitability by virtue of routing those costs through an Affiliate.

(5) Administrative expense assessment "true-up." Affiliate administrative services Subcontracts (e.g., a Subcontract with the MTO's parent for headquarter support functions) must be limited to allowable costs incurred by the Affiliate. In many cases, these Subcontracts may be initially paid monthly, based on a pre-determined formula, such as a percentage of the MTO's revenues, a fixed per-member-per-month amount, or a flat monthly amount. When such a formula-based approach is used by an Affiliate, the MTO must do an end-of-year "true-up" of the actual allowable charges incurred by the Affiliate, versus the amounts initially recorded on the FSR by the formula. The MTO must modify the FSR accordingly to represent only allowable costs actually incurred by the Affiliate. Such a true-up must be done, and its impact included into the FSR, no later than the 120-day FSR for each SFY.

E. Managed Transportation owned-fleet and/or Affiliate fleet operating costs

Any MTOs operating owned-fleets for the provision of non-emergency medical transportation services under the Managed Transportation Program, as well as any MTOs contracting with an Affiliate for the provision of such services, are subject to the methodology described herein with respect to the manner in which such transportation operating costs may be included in the FSR.

"Owned-Fleet Transportation Operating Costs," as defined in the section below, are not allowable costs for inclusion in HHSC's FSR report. Instead of reporting costs on the FSR for gasoline, vehicle maintenance, driver wages, etc., the MTO must instead report per-trip fees (and/or any related per-unit-of-service fees), according to a pre-determined

written fee schedule or contract, just as it would for billing any unrelated party under contract for specific services provided.

II. Definitions

Advertising Costs means the costs of Advertising Media and corollary administrative costs, including the MTO's cost of events oriented specifically and narrowly at outreach to potential Medicaid Members in Texas.

Advertising Media means magazines, newspapers, radio and television programs, billboards, bus and bench displays, banners, telephone books, outreach brochures, outreach exhibits, posters, stickers, decals, and internet advertisements. Advertising Media also includes promotional items and memorabilia, such as low-cost-per-item giveaways, souvenirs, and models, if these items are distributed to Program-eligible individuals or their family members. In order to qualify as Advertising Media, the item in question must be designed or intended to be read, heard, or seen by Medicaid Members or potential members in Texas.

Allocable Cost means a cost that is allocable to the Contract if: (a) the goods or services involved are specifically chargeable or assignable to the Contract in accordance with relative benefits received, (b) all activities which benefit from MTO's indirect cost will receive an appropriate allocation of indirect costs, (c) any cost allocable to the Contract under the principles provided for in this document may not be charged to other contracts to overcome deficiencies, to avoid restrictions imposed by law or terms of such contracts, or for other reasons.

Allowable Expenses are defined in Contract Terms and Conditions. A designation of "allowable" or "unallowable" does not generally govern whether the MTO can incur a cost or make a payment; allowability only reflects what is reportable on the FSR. To be allowable, expenses must conform to the requirements of the Cost Principles, which include being reasonable and allocable.

Direct Costs means those costs that can be identified specifically with and are readily assignable to the objectives of this Contract. A particular type of cost may benefit one or more other activities of MTO, but a portion of such cost may be readily assignable to the Contract 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 Contract are generally categorized as direct costs. However, any direct cost of a minor amount may be treated as an indirect cost for reasons of practicality where the accounting treatment for such costs is consistently applied to all activities of the MTO.

Directly Associated Cost is defined in 48 CFR § 31.001.

Experience Rebate is defined in the Contract Terms and Conditions.

Indirect Costs means those incurred for a common or joint purpose benefiting the Contract and one or more other activities of the MTO and are not readily assignable to the activities specifically benefited, without effort disproportionate to the results

achieved. To facilitate equitable distribution of indirect expenses to the activities benefited, it may be necessary to establish a number of pools of indirect costs within the various departments of the MTO. 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 Contract, the MTO is not allowed to include any indirect costs which do not benefit the objectives under the Contract.

Marketing Expenses means certain marketing-related expenses that are:

1) allowable for inclusion in the FSR, and
2) are to be recorded on the Marketing line in the Administrative Expenses tab of the FSR.

Note that this is a more narrow definition than in the classic business sense. In this regard, Marketing Expenses are largely tied to outreach efforts, and do not include certain allowable related other costs, such as general public relations or advertising for recruitment of personnel. For more specific details, see "Marketing, Advertising, and Public Relations Costs" under Section VI, "Cost Categories."

Other Marketing Costs means any marketing costs that do not fall under the categories of Advertising Costs or Public Relations Costs.

Owned-Fleet Transportation Operating Costs means the direct costs of running and operating vehicles for the provision of non-emergency medical transportation services. This includes vehicles either owned, leased, or under the operating control of the MTO, or any Affiliate of the MTO. This also includes drivers and related personnel that are either on the payroll of, or under the operating control of, the MTO or any Affiliate of the MTO. Such direct costs include, but are not limited to, vehicle maintenance and repair; vehicle and related equipment depreciation; vehicle leasing or rental costs; related insurance; gasoline, oil, tires, parts, and supplies; salaries, wages, benefits, per trip fees, and any other compensation paid to drivers, mechanics, and fleet operations personnel; related space costs, including fleet operations garage or office building rent, lease, mortgage, interest, insurance, utilities, etc.; any fleet related taxes, regulatory fees, payroll processing fees, bookkeeping costs, legal fees, or professional services; fleet-related office supplies, telecom, internet and broadband costs; management overhead and/or assessments; and, any other costs or expenses that would normally pertain to the income statement of a fleet operations department or company.

Pre-implementation Costs means those costs incurred by the MTO on or after the Effective Date of the Contract but prior to the Operational Start Date of the Contract. Pre-implementation expenses are an allowable expense to Rate Period 1, subject to the limitations contained in Uniform Managed Care Contract Terms and Conditions, Article 10. Expenses must be reported for each month in which the expenses were incurred and must be reported separately in the Financial Statistical Report (FSR). These expenses must be counted toward the calculation of total expenses for the first FSR reporting period for the purposes of calculating the net income before taxes. These expenses must not be allocated or amortized beyond the first FSR reporting period.

Public Relations Costs means the MTO's costs of community relations and those activities dedicated to maintaining the image of the MTO, or maintaining or promoting understanding and favorable relations with the community, public at large, or any segment of the public. This includes MTO news releases and MTO press releases.

Reasonable Cost means a cost that, in its nature and amount, does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. In determining reasonableness of a given cost, consideration must be given to: (a) whether the cost is of a type generally recognized as ordinary and necessary for the operation of the MTO or the performance of the services required under the Contract, (b) the restraints or requirements imposed by such factors as: sound business practices; arms length bargaining; federal, state, and other laws and regulations; and, terms and conditions of the Contract, (c) market prices for comparable goods or services, (d) whether the individuals concerned acted with prudence in the circumstances considering their responsibilities to the MTO, its employees, the public at large, and the State of Texas, and (e) significant deviations from the established practices of the industry which may unjustifiably increase the cost incurred by the MTO to provide the services required under the Contract. To be allowable, "reasonable" costs still must meet requirements under the Cost Principles, especially with respect to Affiliate transactions.

III. Applicable Credits

Applicable credits refer to those receipts or reduction of expenditure-type transactions that offset or reduce expense items allocable to the Contract 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 MTO relate to allowable costs, they must be credited to this Contract either as a cost reduction or an increase in revenues, as appropriate.

IV. Composition of Administrative Costs

The total administrative expenses of the Contract are comprised of the allowable direct costs of the program, plus its allocable portion of allowable indirect costs, less applicable credits. There is no universal rule for classifying certain costs as either direct or indirect under every accounting system. A cost may be direct with respect to some specific service or function of the MTO but indirect with respect to the objectives under the Contract. Therefore, it is essential that each item of cost be treated consistently in like circumstances either as a direct or an indirect cost.

Fees based on profitability. Between affiliated entities, variable fees (or cost rates) that are dependent on the *level* of profitability are unallowable, except when HHSC grants a specific written exception, which will only be granted when it is in the best interest of HHSC or its constituents. Any MTO desiring an exception must submit a formal written request, demonstrating the reasonableness, the clear benefit to the program, the proposed methodology, and the financial implications.

V. Allocation of Indirect Costs

Unless specifically allowed by HHSC, indirect costs that are assessed or allocated by a parent company or affiliate to the relevant operating subsidiary are only allowable to the extent that: (a) the costs clearly represent specifically identified operating services provided for the operating subsidiary; and (b) the services directly benefit HHSC or its clients/customers (i.e., Medicaid Members).

These specifically identified and directly beneficial services would include core operating functions (e.g., centralized accounting, billing, IT), but would not include or allow items such as: vague management allocations where there is no clear and direct identifiable benefit to the contract, or fees that are assessed in addition to total (direct and indirect) costs, or overhead expenditure levels deemed clearly unreasonable (e.g., travel by private jet). During any audit verification or prospective contract review, expenditures must be broken out separately by function and meet the test of reasonability, and other requirements described in the Cost Principles.

The MTO must develop a written cost allocation methodology policy. The allocation methodology is subject to audit, and must allocate costs in an appropriate manner.

See also "Administrative expense assessment 'true-up'" and other portions of Section I(D).

VI. Cost Categories

1. Accounting. The cost of establishing and maintaining accounting and other information systems is allowable.
2. Add-on Fees. Amounts paid to an Affiliate that are in excess of actual costs incurred by the Affiliate, or that do not represent a pass-through of the actual costs of the Affiliate, are unallowable for cost-reporting on the FSR. This includes profit, margin, or mark-ups added to, or included in, Affiliate costs. Certain exceptions may apply; see Section I(D)(3), "Exceptions to Affiliate cost-based reporting."
3. Administrative Assessments. Certain parent company cost assessments for various administrative services provided to the MTO are allowable. However, any administrative services fees paid to, or assessed by, a parent or other Affiliate, which are unsupported in terms of actual documented specific allowable costs incurred by the Affiliate, are unallowable for cost-reporting on the FSR.
4. Advisory Councils. Costs incurred by advisory councils or committees are generally unallowable; any exceptions would require advance review by HHSC and would be subject to audit.
5. Alcoholic Beverages. Costs of alcoholic beverages are unallowable.
6. Audit Services. The costs of audits are allowable provided that the audits were performed in accordance with Generally Accepted Auditing Standards promulgated by the American Institute of Certified Public Accountants.

7. Automatic Electronic Data Processing. The cost of data processing services is allowable.

8. Bad Debts. Any losses arising from uncollectible accounts and other claims, and related costs, are unallowable.

9. Bonding Costs. Costs of bonding employees and officials are allowable to the extent that the bonding is in accordance with sound business practice.

10. 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.

11. Budgeting. Costs incurred for the development, preparation, presentation, and execution of budgets are allowable.

12. Capital expenditures. Expenditures for equipment or buildings, or repairs that materially increase the value or useful life of buildings or equipment, should be capitalized, and are unallowable, in terms of being totally expensed when initially incurred. Depreciation of these capital expenditures, and maintenance expenses, in accordance with Generally Accepted Accounting Principles (GAAP), OMB Circular A-122, or the Federal Acquisition Regulations (FAR), are allowable.

13. Communications. Costs of telephone, mail, messenger, and similar communication services are allowable.

14. 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 Contract, including wages, salaries, and fringe benefits. The costs of compensation are allowable to the extent that they satisfy the specific requirements of the Cost Principles, and that the total compensation for individual employees:

        1. Is reasonable for the services rendered and conforms to the established policy of the MTO consistently applied to all of its activities;

        2. Follows an appointment made in accordance with the MTO's policies and meets merit system or other requirements required by Federal law, where applicable; and

        3. Is determined and supported as provided in Section VI(14)(h).

    b. Reasonableness. Compensation for employees engaged in work on the Contract will be considered reasonable to the extent that it is consistent with that paid for similar work in other activities of the MTO. In cases where the kinds of employees required for the Contract are not found in the other activities of the MTO, compensation will be considered reasonable to the extent that it is comparable to that paid for similar work in the labor market in which the MTO competes for the kind of employees involved. Compensation surveys providing data representative of the labor market involved will be an acceptable basis for evaluating reasonableness.

c. Unallowable Costs. Costs that are unallowable under other sections of the Cost Principles will not be allowable under this section solely on the basis that they constitute personnel compensation.

d. Fringe benefits.

1. Fringe benefits are allowances and services provided by employers to their employees as compensation in addition to regular salaries and wages. Fringe benefits include the costs of leave, employee insurance, pensions, and unemployment benefit plans. Except as provided elsewhere in these principles, the costs of fringe benefits are allowable to the extent that the benefits are reasonable and are required by law, the MTO-employee agreement, or an established policy of the MTO.

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 MTO; and (c) the accrual basis of accounting utilized for costing each type of leave is consistently followed by the MTO.

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 MTO 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; employee life, health, unemployment, and worker's compensation insurance (except as indicated in Section VI(28), “Insurance and Indemnification”); pension plan costs (see Section VI(14)(e)); 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 Contract and all other activities of the MTO 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 Contract.

e. Pension Plan Costs. Pension plan costs may be computed using an acceptable actuarial cost method recognized by GAAP in accordance with established written policies of the MTO.

1. Pension costs calculated using an actuarial cost-based method are allowable for a given fiscal year if they are funded for that year within six months after the end of that year. Costs funded after the six-month period (or a later period agreed to by HHSC) are allowable in the year funded.

2. Amounts funded by the MTO in excess of the actuarially determined amount for a fiscal year may be used as the MTO's contribution in future periods.

3. The Contract must receive an equitable share of any previously allowed pension costs (including earnings thereon) which revert or inure to the MTO in the form of a refund, withdrawal, or other credit.

f. Post-Retirement Health Benefits. Post-retirement health benefits (PRHB) refers to costs of health insurance or health services not included in a pension plan covered by Section VI(14)(e) for retirees and their spouses, dependents, and survivors. PRHB costs may be computed using an acceptable actuarial cost method recognized by GAAP in accordance with established written polices of the unit.

1. PRHB costs calculated using an actuarial cost method recognized by GAAP are allowable if they are funded for that year within six months after the end of that year. Costs funded after the six-month period (or a later period agreed to by HHSC) are allowable in the year funded.
2. Amounts funded in excess of the actuarially determined amount for a fiscal year may be used as the MTO's contribution in a future period.
3. To be allowable in the current year, the PRHB costs must be paid either to:

   (a) The MTO or other benefit provider as current year costs or premiums, or

   (b) The MTO or trustee to maintain a trust fund or reserve for the sole purpose of providing post-retirement benefits to retirees and other beneficiaries.
4. The Contract must receive an equitable share of any amounts of previously allowed post-retirement benefit costs (including earnings thereon) that revert or inure to the MTO in the form of a refund, withdrawal, or other credit.

g. Severance Pay.

1. Payments in addition to regular salaries and wages made to rank-and-file workers whose employment is being terminated are allowable to the extent that, in each case, they are required by (a) law, (b) a group employer-employee agreement, or (c) established written policy.
2. Severance payments (but not accruals) associated with normal turnover are allowable. Such payments must be allocated to all applicable activities of the MTO as an indirect cost.
3. Executive severance, abnormal, or mass severance pay will be considered on a case-by-case basis and is generally unallowable; any exceptions would require advance review by HHSC and would be subject to audit.

h. Support of Salaries and Wages. These standards regarding time distribution are in addition to the standards for payroll documentation.

1. Charges to the Contract for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted practice of the unit and approved by a responsible official(s) of the MTO.

2. No further documentation is required for the salaries and wages of employees who work in a single indirect cost activity.

3. Where employees are expected to work solely on a single contract, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that contract for the 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.

4. Where employees work on multiple activities, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation that meets the standards in Section VI(14)(h)(5) 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 MTO.

5. Personnel activity reports or equivalent documentation must meet the following standards:

   (a) They must reflect an after-the-fact distribution of the actual activity of each employee,

   (b) They must account for the total activity, for which each employee is compensated,

   (c) They must be prepared at least monthly and must coincide with one or more pay periods, and

   (d) They must be signed by the employee.

   Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to the Contract but may be used for interim accounting purposes, provided that:

   (a) The MTO's system for establishing the estimates produces reasonable approximations of the activity actually performed; and

   (b) 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.

6. Substitute systems for allocating salaries and wages to the Contract may be used in place of activity reports. These systems are subject to advance review by HHSC and will be subject to audit.

i. Employee Bonuses or Incentive Payments.

1. Employee bonuses are allowable if they are:

   (a) Part of and in conformance with an existing plan that has been submitted at least nine months in advance to HHSC, and which is in compliance with any relevant specific terms of the Contract, such as those describing the criteria required for an employee bonus or incentive payment plan;

(b) Based on individual or group performance with respect to clearly-stated goals within a defined period (generally either the MTO's fiscal year, the MTO Parent's fiscal year, the calendar year, or the FSR reporting period); and

(c) Paid after the end of and within 90 days of the defined period, and is not contingent upon future services any recipient would provide.

2. Bonuses paid or payable to an Affiliate are unallowable.

15. 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. The term "contingency reserve" excludes self-insurance reserves (see Section VI(28)(d)), pension plan reserves (see Section VI(14)(e)), and post-retirement health and other benefit reserves (see Section VI(14)(f)) computed using acceptable actuarial cost methods.

16. Contributions and Donations. Contributions and donations, including cash, property, and services, regardless of the recipient, are unallowable.

17. Cost of capital. Expenses representing the cost of capital in any manner are unallowable.

18. Defense and Prosecution of criminal proceedings, civil proceedings, and claims are generally unallowable.

a. An exception exists for an MTO to identify, investigate, or pursue recoveries relating to suspected Fraud, Abuse, or Waste of providers or unaffiliated subcontractors providing services under the Texas Medicaid contracts, as well as to assist with the prosecution of suspected Fraud, Abuse, or Waste with these providers or unaffiliated subcontractors. This exception includes reasonable associated costs incurred in:

1. identifying, investigating, or pursuing Fraud, Waste, or Abuse under the Texas Medicaid contracts;

2. any related cooperation with or assistance provided to any state or federal agency; and

3. related defense costs that arise as a result of actions against providers and unaffiliated subcontractors.

Costs incurred under this exception do not have to result in actual recoveries in order to qualify.

b. An exception exists for reasonable legal costs related to subrogation, third party recoveries, and provider credentialing matters, which are allowable if these costs are incurred directly in the administration of the Contract with HHSC.

However, no exception extends to the payment by the MTO or any Affiliate of any fines, penalties, settlements, imposed court costs or attorney fees, sanctions, damages, interest, or related types of expenses.

Legal or related costs are not allowable for prosecution of claims against a state or the Federal government or other governmental body; or in connection with any criminal, civil, or administrative proceeding commenced by a state or Federal government or any other governmental body.

19. Depreciation and Amortization.

    a. Depreciation and amortization are a means of allocating the cost of fixed assets and intangible assets to periods benefiting from asset use, respectively. Depreciation for a particular class of assets (e.g., buildings, office equipment, computer equipment) and amortization for a particular class of assets (e.g. patents, leasehold improvements) charged to the Contract must be determined on the same basis used for the entity-wide financial statements.

    b. The computation of depreciation must be based on the acquisition cost of the assets involved. The value of an asset donated to the MTO by an unrelated third party must be its fair market value at the time of donation.

    c. Charges for depreciation and amortization must be supported by adequate property records, including the amount of depreciation and amortization taken each period.

    d. Charges for amortization of intangible assets are allowable only to the extent that they represent direct costs for the acquisition of proprietary processes (patents, copyrights, etc.) to be used exclusively in fulfilling the objectives of the Contract. Charges for amortization of intangible assets not related to proprietary processes, such as goodwill and debt acquisition costs, are unallowable.

20. Employee Health and Welfare Costs. The costs of health or first-aid clinics or infirmaries, employee counseling services, employee information publications, and any related expenses incurred in accordance with the MTO's policy are allowable. Income generated from any of these activities will be offset against expenses.

21. 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.

22. 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, are unallowable except when incurred as a result of compliance with specific provisions of the Contract or written instructions by HHSC authorizing such payments in advance.

23. Income taxes. Federal, state, and local taxes on income are unallowable. This includes excess profit taxes; corporate income taxes paid by a parent; and other income taxes paid by a parent or other Affiliate.

24. Investment Management Costs. Costs of investment counsel and staff and similar expenses incurred to enhance income from investments are unallowable.

25. Liquidated Damages paid to the Health and Human Services Commission, and any other similar fines, penalties, or settlement payments, are unallowable.

26. Losses on Disposition of Depreciable Property and other capital assets are unallowable.

27. Idle Facilities and Idle Capacity.

    a. As used in this Section the following terms have the meanings set forth below:

        1. 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 MTO.

        2. Idle facilities means completely unused facilities that are excess to the MTO's current needs.

        3. 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.

        4. 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 are unallowable.

28. Insurance and Indemnification.

    a. Costs of insurance that is required and maintained pursuant to the Contract are allowable but subject to audit.

    b. Costs of other insurance in connection with the general conduct of activities are allowable if the types, extent, and cost of coverage are in accordance with the MTO's policy and sound business practice.

    c. Actual losses that could have been covered by permissible insurance (through a self-insurance program or otherwise) are unallowable, unless expressly provided for in the Contract or as described below. Costs incurred because of losses not covered under nominal deductible insurance coverage provided in keeping with sound management practice, and minor losses not covered by insurance, such as spoilage, breakage, and disappearance of small hand tools which occur in the ordinary course of operations, are allowable.

    d. Contributions to a reserve for certain self-insurance programs including workers' compensation, unemployment compensation, and severance pay are allowable subject to the following provisions.

        1. The type of coverage, the extent of coverage, and the rates and premiums would have been allowed had insurance (including reinsurance) been purchased to cover the risks. However, provision for known or reasonably estimated self-insured liabilities, which do not become payable for more than

one year after the provision is made, must not exceed the discounted present value of the liability. The rate used for discounting the liability must be determined by giving consideration to such factors as the settlement rate for those liabilities and its investment rate of return.

2. Earnings or investment income on reserves must be credited to those reserves.

3. Contributions to reserves must be based on sound actuarial principles using historical experience and reasonable assumptions. Reserve levels must be analyzed and updated at least biennially for each major risk being insured and take into account any reinsurance, coinsurance, etc. Reserve levels related to employee-related coverage will normally be limited to the value of claims (a) submitted and adjudicated but not paid, (b) submitted but not adjudicated, and (c) incurred but not submitted. Reserve levels in excess of the amounts based on the above must be identified and justified in the cost allocation plan or indirect cost rate proposal.

4. Accounting records, actuarial studies, and cost allocations (or billings) must recognize any significant differences due to types of insured risk and losses generated by the various insured activities or agencies of the governmental unit. If the MTO experiences significantly different levels of claims for a particular risk, those differences are to be recognized by the use of separate allocations or other techniques resulting in an equitable allocation.

5. Whenever funds are transferred from a self-insurance reserve to other accounts (e.g., general fund), refunds must be made to HHSC for its share of funds transferred, including earned or imputed interest from the date of transfer.

e. Actual claims paid to or on behalf of employees or former employees for workers' compensation, unemployment compensation, severance pay, and similar employee benefits (e.g., post retirement health benefits), are allowable in the year of payment provided (1) the MTO follows a consistent costing policy, and (2) they are allocated as a general administrative expense to all activities of the MTO.

f. Insurance refunds must be credited against insurance costs in the year the refund is received.

g. Indemnification includes securing the MTO against liabilities to third persons and other losses not compensated by insurance or otherwise. HHSC is obligated to indemnify the MTO only to the extent expressly provided for in the Contract.

29. Interest. In general, interest expense is unallowable. This includes interest expense incurred by a parent or other Affiliate. Costs incurred for interest on borrowed capital or the use of the MTO's own funds, however represented, are unallowable, except as provided in Section VI(41)(d) (regarding rental costs for certain leases).

30. Lobbying. The cost of activities associated directly or indirectly with influencing local state or federal legislation is an unallowable cost.

31. 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 to the extent that they: (1) keep property in an efficient operating condition, (2) do not add to the permanent value of property or appreciably prolong its intended life, and (3) are not otherwise included in rental or other charges for space. Costs that add to the permanent value of property or appreciably prolong its intended life must be treated as capital expenditures.

32. Marketing, Advertising, and Public Relations Costs.

a. Applicability

This Section describes the advertising, marketing, promotional, outreach, and public relations activities (collectively "marketing activities") that an MTO is permitted to *record as an allowable expense* on the FSRs. For rules concerning *permissible* marketing activities, refer to the Contract's section on Marketing Policies and Procedures. A marketing activity may be permissible under the Contract's section on Marketing Policies and Procedures, but not an allowable expense for purposes of FSR reporting. A communication from HHSC regarding specific permitted marketing practices does not override language in this Section regarding the allowability of expenses.

This section describes the costs allowable for inclusion on the FSR, and the specific line items for recording those costs on the FSR.

b. Costs That Are Allowable as Marketing Expenses on the FSR

The following costs are allowable as deductible expenses on the FSR, subject to the limitations as listed under Section VI(32)(d), "Unallowable Costs". MTO should record the following costs on the Marketing Expenses line item on the FSR.

1. Advertising Costs, when incurred by the MTO for promotional and outreach efforts, if all three of the following criteria are met:

(i) an HHSC Program that the MTO participates in is mentioned within the promotional or outreach materials;

(ii) the advertising (or related activity) is not in violation of the Contract's section on Marketing Policies and Procedures; and

(iii) the primary target audience consists of Medicaid or Program eligibles in Texas.

2. Other Marketing Costs, when incurred by the MTO for the following items:

(i) member surveys;

(ii) member focus groups and advisory committees;

(iii) materials or events oriented specifically at member education or community health education;

(iv) certain Marketing Incentives (of such Incentives are defined and allowed in the Contract);

(v) non-cash promotional items and giveaways valued at $10 or less each, that are distributed solely to current or prospective Texas Medicaid Members or their families; or

(vi) reasonable payments for booth rentals at events attended by the MTO for member outreach purposes, which events are attended by prospective Texas Medicaid Members or their families.

c. Related Costs That Are Allowable on the FSR, But Not as Marketing Expenses

The following costs are allowable as deductible expenses on the FSR, subject to the limitations as listed under Section VI(32)(d), "Unallowable Costs," but should NOT be recorded on the Marketing Expenses line item on the FSR.

1. Provider directories, provider manuals, and member handbooks. These items are not considered to be Marketing Expenses for FSR reporting purposes. Costs associated with directories, manuals, and handbooks should be recorded under Printing or Postage, as may be appropriate. If an external firm handles some of this effort, the Outsourced Services line item may be utilized for the appropriate portion of those costs. Any allowable related costs that do not fit under these line items should be recorded under Other Administrative Services.

2. Mailing and printing costs for correspondence with current members. These items are not considered Marketing Expenses, unless a specific effort is primarily oriented towards member retention or member renewal. Allowable costs associated with these items should be recorded in the same manner described above for directories, provider manuals, and handbooks.

3. Certain non-marketing Advertising Costs, when incurred by the MTO for:

(i) the recruitment of personnel to perform services for the HHSC Program(s);

(ii) the procurement of goods and services for the HHSC Program(s);

(iii) the disposal of surplus materials directly by the MTO; or

(iv) certain limited other cases, where the incurrence of Advertising Costs are necessary to meet the requirements of the Contract with HHSC.

These non-marketing Advertising costs should be recorded as Other Administrative Expenses.

4. Public Relations Costs incurred by the MTO as a direct, non-allocated cost for public relations activities are allowable in the following circumstances:

(i) public relations activities required by the Contract with HHSC;

(ii) costs incurred to communicate with the public and press pertaining to specific activities, accomplishments, or outcomes that result from

performance of services under the Contract with HHSC, as long as the MTO includes the name of the applicable HHSC Program(s);

(iii) costs related to the Contract with HHSC that are incurred to:

(A) respond to inquiries on the MTO's policies and activities;

(B) communicate with the public and press; or

(C) conduct general communication with news media, to the extent that the activities are limited to communication necessary to keep the public informed on matters of public concern such as notice of contract awards, facility closings or openings, employee layoffs or rehires, financial information; and

(iv) costs of MTO participation in community service activities (e.g., blood bank drives, charity drives, disaster assistance).

Valid Public Relations costs should be recorded in the FSR on appropriate line items similar to as described under website hosting costs in this Section.

5. Basic website costs, including home-site hosting, site maintenance, etc. These items are not considered Marketing Expenses, unless the cost is dedicated to the procurement of internet advertising. Hosting and maintenance should be recorded under Salaries for that portion that represents in-house efforts, to Outsourced Services for appropriate external fees, and otherwise to Other Administrative Expenses.

6. Marketing-related and Public Relations related overhead allocations (or assessments), from a parent (or other Affiliate). Such allocations and assessments generally should be recorded under Affiliate Company Allocations/Charges. An exception to this would be for a cost that solely represents a direct net payment to an unaffiliated third party, wherein the payment is specifically for advertising directed to Program-eligible populations in Texas, in which an HHSC Program is mentioned.

7. Costs of professional and industry organizations, associations, and periodicals, including memberships, subscriptions, meeting costs, and associated dues, fees, contributions, reimbursements, etc. Valid costs associated with these professional association items should be recorded under Other Administrative Expenses.

8. Other related marketing and advertising type costs that are allowable per the Contract's section on Marketing Policies and Procedures, but excluded from being reported on the Marketing Expense line, should be reported on the FSR under Other Administrative Expenses if the MTO determines that no other line item is appropriate.

d. Unallowable Costs

Advertising Costs, Public Relations Costs, and Other Marketing Costs that are not allowable expenses on the FSR include the following.

1. Any media or efforts that do not mention the MTP Program. An exception to

this is non-cash promotional items and giveaways valued at $10 or less each, which are distributed solely to current or prospective Texas Medicaid Members or their families.

2. Any activity that does not comply with the Contract's section on Marketing Policies and Procedures.
3. Any costs associated with any of the following:
   (i) any written or oral statements containing material misrepresentations of fact or law, or that are in any manner determined by HHSC to be significantly misleading;
   (ii) usage of "Spam," as defined by the Contract's section on Marketing Policies and Procedures;
   (iii) materials used or efforts directed, in whole or in part, at anything unrelated to the applicable HHSC Program;
   (iv) activities outside the State of Texas;
   (v) royalty fees or franchise fees;
   (vi) gifts or gratuities (excluding certain low-cost-per-item mass-produced promotional giveaway items, as may be allowed under the requirements of Section VI(32)(b)(2));
   (vii) charitable donations of any kind, including cash contributions to non-profit organizations, and paid sponsorships;
   (viii) Value-Added Services;
   (ix) the costs of conventions, retreats, gatherings, parties, awards presentations, appreciation events, celebrations, entertainment, non-outreach activities, internal meetings, or events related to internal activities of the MTO or its Affiliates;
   (x) expenses related to events described in Section VI(32)(d)(3)(ix) above, including costs associated with displays, demonstrations, and exhibits; costs of meeting rooms and hospitality suites; and any related airfare, lodging, meals, car rental, fuel, taxi, mileage, parking, laundry, entertainment, and other travel expenses;
   (xi) unsolicited direct mail to non-members; cold-calling; door-to-door marketing; or acquisition or development of non-member mailing lists;
   (xii) fees (including assessments, allocations, overhead, or other charges) invoiced from a parent organization (or other Affiliate), for any advertising related costs, public relations related costs, or other marketing expenses. An exception to this would be where any costs pertain directly and solely to an HHSC Program, and represent only the direct net external payment to an unaffiliated third party.
4. Costs of memberships in civic or community organizations, including dues and expenses associated with country club and fraternal organizations.

5. Political contributions or costs associated with lobbying, and any costs associated with elected officials or candidates.

6. Any costs or activities that do not comply with OMB Circular A-122 or the Federal Acquisition Regulations (FAR), including 42 C.F.R. § 438.104.

33. Materials and Supplies. The cost of materials and supplies is allowable. Purchases should be charged at their actual prices after deducting all cash discounts, trade discounts, rebates, and allowances received. Withdrawals from general stores or stockrooms should be charged at cost under any recognized method of pricing, consistently applied. Incoming transportation charges are a proper part of materials and supply costs.

34. Memberships, Subscriptions, and Professional Activities.

    a. Costs of the MTO's memberships in business, technical, and professional organizations are allowable.

    b. Costs of the MTO'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 Section VI(47), "Travel Costs."

    d. Costs of membership in civic and community social organizations are unallowable.

    e. Costs of membership in organizations substantially engaged in lobbying are unallowable.

35. Motor Pools. The costs of a service organization that provides automobiles to the MTO at a mileage or fixed rate or provides vehicle maintenance, inspection, and repair services are allowable.

36. Pre-implementation Costs. Pre-implementation costs are certain costs incurred between the date of tentative Contract award, and the Effective Date of the Contract. Pre-implementation costs are allowable if such costs are included in a separate Implementation FSR submission (which is submitted within HHSC's timelines), and meet all of the following criteria.

    a. The costs are Reasonable Costs and would otherwise be allowable (if they had been incurred on or after the Effective Date) under the provisions of the Contract, and are necessary for the MTO to implement the Contract.

    b. The costs are Direct Costs under the provisions of the Contract.

    c. The costs are incremental. A cost is incremental if it would not have been incurred by the MTO in the absence of the Contract. For example, allocations of compensation costs for individuals who were employed by the MTO prior to or commensurate with the Effective Date of the Contract are reimbursable only if:

(1) the MTO can demonstrate that the employees were hired solely to provide services under the Contract, or received additional compensation (such as overtime) for services directly related to implementation of the Contract, or

(2) the MTO can support that the employees did work on Contract issues evidenced by supporting documentation such as time and attendance sheets or monthly work analysis worksheets.

Any allocated expenses (such as postage, office supplies, telephone, utilities, and printing) must be supported by an allocation methodology and documentation that the expense was necessary for Contract implementation. Costs associated with developing the RFP proposal response are not considered to be Pre-implementation Costs, and are unallowable.

d. If costs are paid or payable, directly or indirectly, to an Affiliate, supporting documentation must reflect that the MTO has not included on the FSR reporting any amounts paid to Affiliates for goods and services that would be deemed unallowable expenditures under the Contract (if they had been incurred on or after the Effective Date). See Section I(D), "Affiliate transactions and Affiliate cost reporting."

   Pre-implementation costs require submission of a specified spreadsheet and other documentation as may be prescribed by HHSC or its auditor. There are certain limitations for these costs in terms of the potential carry-forward of any Rate Period 1 losses.

   Costs incurred prior to the notification of Contract award, which may be incurred in anticipation of the award of the Contract, or in connection with Contract negotiations, bid preparation, or RFP submission, etc., are unallowable.

37. Professional Service Costs.

   a. 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 MTO, are allowable if they: are reasonable in relation to the services rendered; are not contingent upon recovery of the costs from HHSC; and do not conflict with any other provisions of the Cost Principles.

   b. Retainer fees supported by evidence of bona fide services available or rendered are allowable.

38. Proposal Costs. Costs of preparing proposals for potential contracts are unallowable.

39. 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.

40. Rebates and profit sharing. Unless specifically allowed by the HHSC contract, 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 contract, such that the fee is effectively a form of profit payment or rebate to the Affiliate, are unallowable unless specifically allowed by the HHSC contract.

41. Rental Costs.

    a. Subject to the limitations described in Sections VI(41)(b) through (41)(d), rental costs are allowable to the extent that the rates are reasonable when considering: rental costs of comparable property, if any; market conditions in the area; alternatives available; and the type, life expectancy, condition, and value of the property leased.

    b. Rental costs under sale and leaseback arrangements are allowable only up to the amount that would be allowed had the MTO continued to own the property.

    c. Rental costs under less-than-arms-length leases are allowable only up to the amount that would be allowed had title to the property vested in the MTO. For this purpose, less-than-arms-length leases include those where:

        1. One party to the lease is able to control or substantially influence the actions of the other;

        2. Both parties are parts of the same MTO, share the same parent, or are otherwise Affiliates; or

        3. The MTO creates an authority or similar entity to acquire and lease the facilities to the MTO and other parties.

    d. Rental costs under leases required to be treated as capital leases under GAAP, are allowable only up to the amount that would be allowed had the MTO purchased the property on the date the lease agreement was executed. This amount would include expenses such as depreciation, interest, maintenance, and insurance. The provisions of Financial Accounting Standards Board Statement 13 must be used to determine whether a lease is a capital lease.

42. Retrocession Agreements. "Retrocession" refers to a transaction where a reinsurer cedes or transfers back to the insured or its designee all or part of the reinsurance that the reinsurer previously assumed. While the reinsurer is "providing" ongoing reinsurance to the insured in one contract, it is simultaneously relieving itself of all or part of that reinsurance obligation in another contract. In conjunction with this transfer of risk away from the reinsurer, a retrocession agreement may involve the return of reinsurance premiums back to the insured or its designee, or the remitting of other payments from the reinsurer to the insured or its designee, that have the effect of substantially offsetting or reducing the gross amount that had been paid to the reinsurer by the insured in the original reinsurance.

    Any retrocession agreement that would impact FSR reporting and that fails to strictly meet the requirements of the Cost Principles prior to audit may be deemed a material breach of the Contract. A retrocession agreement may be permissible under the Contract only if it meets all the criteria listed in this section.

Any retrocession payments made by a reinsurer or its Affiliate that are related in any manner to the costs incurred or services performed under the MTO Contract, and which payments are or may be received by an MTO or an Affiliate, must be included in the FSR as a "contra-cost," or an offset to other reported costs, thus reducing overall expenses reported. Any retrocession payments that are contractually required due to activity in a given State Fiscal Year (SFY) must be reported in that SFY's FSR reporting, even if the payments are not received until a subsequent SFY. Retrocession agreements may not be utilized to shift FSR-reported profitability either between years or out of the MTO.

Copies of all retrocession agreements relating to the MTO Contract, including any amendments or renewals, must be sent to HHSC in advance of any usage which could be deemed to impact cost reporting on the FSR. Retrocession agreements, amendments, and renewals must receive HHSC's prior written approval and are subject to audit.

The above requirements (including the requirement to send copies in advance to HHSC) also apply to:

- any retrocession agreement (or payment) between an Affiliate and a third party, if the agreement (or payment) would affect the reported cost on the FSR; and,
- any "interests and liabilities contract" associated with any reinsurance agreement; "excess of loss reinsurance binder;" reinsurance-related "experience refunds;" and other arrangements that may affect similar mechanisms; and,
- any agreement or arrangement with a third party that wholly or partially negates, or significantly offsets, any reinsurance with the third party or any of its affiliates.

43. Risk Mitigation. Risk mitigation refers to the shifting of financial risk to another entity, in exchange for a payment. For purposes of FSR reporting, a reinsurance arrangement will be considered to have accomplished "risk mitigation" only to the extent that the arrangement shifts risk to a non-Affiliate. Further, retrocession arrangements may have the effect of cancelling all or part of the risk mitigation. Reinsurance is only an allowable cost to the extent that it accomplishes Risk Mitigation. Certain types of "reinsurance" that are utilized primarily as a financing mechanism may not be deemed by HHSC to accomplish Risk Mitigation, or the cost may be deemed to only partially pertain to Risk Mitigation.

44. Royalty Agreements (including associated fees, payments, expenses, and premiums). Payments to an Affiliate for any form of royalty are unallowable. This includes fees, payments, expenses, premiums, assessments, and overhead allocations to recognize the advantage or value of proprietary systems, business products, processes, and methodologies; intellectual property; brand name recognition; logos; experience and expertise; and ability to raise capital. Costs for these items are unallowable, regardless of whether they are labeled as royalty payments.

45. Taxes.

a. Income taxes and state franchise taxes are unallowable. In general, other taxes that the MTO is legally required to pay are allowable.

b. Gasoline taxes, motor vehicle fees, and other taxes that are in effect user fees for benefits provided to the federal government are allowable.

c. Any applicable Premium and Maintenance taxes are an allowable charge to the Contract.

d. This provision does not restrict HHSC's authority to identify taxes where state participation is inappropriate. Where the identification of the amount of unallowable taxes would require an inordinate amount of effort, HHSC may accept a reasonable approximation of the unallowable amount.

46. Training. The cost of training provided for employee development is allowable.

47. Employee Travel costs.

a. General. Travel costs for the MTO's employees 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 program. 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 MTO.

b. Lodging and subsistence. Costs incurred by employees and officers for travel, including costs of lodging, other subsistence, and incidental expenses, will be considered reasonable and allowable only to the extent the costs do not exceed charges normally allowed by the MTO in its regular operations as a result of the MTO's policy. 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.

d. Air travel by other than commercial carrier. Cost of travel by the MTO-owned, -leased, or -chartered aircraft, as used in this Section, includes the cost of lease, charter, operation (including personnel costs), maintenance, depreciation, interest, insurance, and other related costs. Costs of travel via the MTO-owned, -leased, or -chartered aircraft are unallowable to the extent they exceed the cost of allowable commercial air travel, as provided for in Section VI(47)(c).

VII. Other Costs

Failure to mention a particular item of cost in this document is not intended to imply that it is either allowable or unallowable; rather, determination of allowability in each case should be based on the treatment or standards provided for similar or related items of

cost. To be allowable as expenses under the Contract, costs must meet the following general criteria:

a. Be a reasonable cost under the provisions of the Contract and be necessary for proper and efficient performance and administration of the Contract.

b. Be an allocable cost under the provisions of the Contract.

c. Be authorized or not prohibited under state or local laws or regulations.

d. Conform to any limitations or exclusions set forth in these principles, terms and conditions of the Contract, laws, or other governing regulations as to types or amounts of cost items.

e. Be consistent with policies, regulations, and procedures that apply uniformly to both the Contract and other activities of the MTO.

f. Be accorded consistent treatment. A cost may not be assigned to the Contract as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Contract as an indirect cost.

g. Except as otherwise provided for in the Contract, be determined in accordance with Generally Accepted Accounting Principles.

h. Not be included as a reimbursable cost or used to meet cost sharing requirements of any other activity of the MTO during the Contract period.

i. Be net of all applicable credits.

j. Be adequately documented.

k. Affiliate costs must meet the same allowability requirements as those for the MTO. Other than the exceptions described in Section I(D), Affiliate costs must represent a pass-through of actual costs incurred by the Affiliate, with no mark-up.

Any legal commitments to make any payments to other parties (or any actual payments made to other parties) do not overrule the requirements described in the Cost Principles.

AGREEMENT BETWEEN THE
TEXAS HEALTH AND HUMAN SERVICES COMMISSION
AND
LOGISTICARE SOLUTIONS, LLC

EXHIBIT I

The **Encounter Data format** as required/described in TMHP 837 Health Care Claim: Professional and the TMHP Companion Guide

Exhibit I
837P_MTO_Companio

Exhibit
I_MT88_MTO_Compar

Exhibit I MTO
Encounter Submissior

Managed Transportation Organizations (MTOs) Encounters Submission Guidelines

April 27, 2017

Version 12.0

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1. Introduction

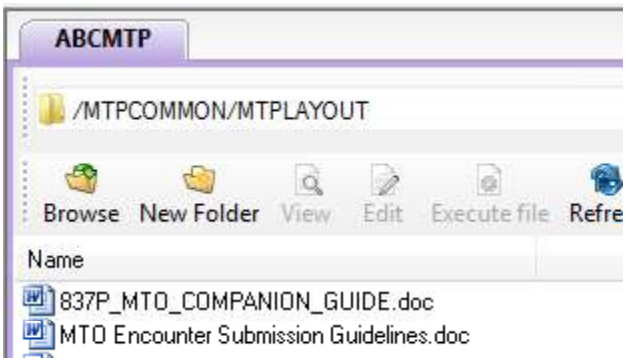
1.1. Purpose

The Managed Transportation Organization (MTO) Encounter Submission Guidelines are designed to assist MTOs with the TMHP specific data sets and business validation of information specified in the National Electronic Data Interchange Transaction Set Implementation Guide for the 837P.

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal government has set standards to simplify Electronic Data Interchange (EDI). To comply with the standard, TMHP has updated the data sets for EDI files to be in accordance with HIPAA and is utilizing the ASC X 12 nomenclatures. This document incorporates Type 1 Errata to the X12N Health Care Claim: Professional Implementation Guide, originally published in January 2007 as 005010X222A1.

The MTO Encounters Submission Guidelines are intended for trading partner use in conjunction with the ANSI ASC X12N National Implementation Guide and the TMHP MTO Encounters Companion Guide. The ANSI ASC X12N Implementation Guides can be accessed at http://www.wpc-edi.com/products/other-insurance/.

MTOs with access to TXMedCentral can find the 837P MTO Companion Guide in the MTPCOMMON/MTPLAYOUT folder.



1.2. Contact Information

If there are questions or if support is required, please contact TMHP at MTOMailbox@tmhp.com.

1.3. Security and Privacy Statement

Covered entities were required to implement HIPAA Privacy Regulations no later than April 14, 2003. A covered entity is defined as a health plan, a Healthcare clearinghouse, or a Healthcare provider who transmits any health information in electronic form in connection with a HIPAA transaction. Providers that conduct certain electronic transmissions are responsible for ensuring these privacy regulations are implemented in their business practices. The Health and Human Services Commission (HHSC) is a HIPAA Covered Entity. Accordingly, TMHP is operating as a HIPAA Business Associate of HHSC as defined by the federally mandated rules of HIPAA. A business associate is defined as a person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce. The privacy regulation has three major purposes:

1. To protect and enhance the rights of consumers by providing them access to their health information and controlling the appropriate use of that information;
2. To improve the quality of Healthcare in the United States by restoring trust in the Healthcare system among consumers, Healthcare professionals and the many organizations and individuals committed to the delivery of Healthcare; and
3. To improve the efficiency and effectiveness of Healthcare delivery by creating a national framework for health privacy and protection.

In accordance with HIPAA privacy regulations, the State of Texas provided a Notice of Privacy Practices to all Texas Medicaid households. As one of the steps in this process, the State of Texas mailed an "Explanation of Medicaid Privacy Rights and a Privacy Notice" to each Medicaid household at the time of enrollment. A copy of the Department of Health and Human Services Privacy Notice is currently available on their website at the following link:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/notice.html

2. Testing

All MTOs are required to complete testing of encounter submission with TMHP prior to submitting encounter data in production.

Testing is required for:

- New MTOs
- MTOs implementing new systems
- MTOs changing ownership
- Any additional Readiness Reviews required by HHSC

There are two phases to testing:

1. HIPAA validation testing through *EDIFECS*

To test for HIPAA validation, each MTO will be provided with a User ID to TMHP's EDIFECS website, http://editesting.tmhp.com. EDIFECS testing is required for the state of Texas regardless of any other HIPAA validation that may be used for encounter files. The MTOs will be responsible for submitting files with at least 50 encounter transactions (Professional) to the EDIFECS website to retrieve their responses and to fix structural and HIPAA level editing (Strategic National Implementation Process (SNIP) levels 1, 2 and 3). The MTOs are expected to test through EDIFECS until all HIPAA errors are resolved. The EDIFECS login and password are originally sent to the MTO in the EDIFECS Invite Email. If additional IDs are required, TMHP contacts listed in Section 1.2 of this guide should be contacted.

2. Business edit validation and end to end testing (including submitting 837 files and processing response files) through the *TMHP EDI Gateway*

Once HIPAA validation has been completed, then the MTO will be expected to submit test files through the TMHP EDI Gateway for business edit validation and end to end testing. TMHP will assign the MTO submitter ID. The submitter ID is how TMHP's system identifies who is sending the file. This ID is used for all files submitted to TMHP in test and production.

TMHP's Receiver ID

- To test, all receiver IDs will be set to **617591011MTPT;**
- For production, all receiver IDs will be **617591011MTPP;** The indicator in **ISA15 must always be set to "P", regardless of the environment**.

3. General Requirements

3.1. Connectivity

All file exchanges for encounters will occur through TXMedCentral in the xxxENC directories set up for each MTO region. See the TXMedCentral SFTP Managed Transportation Organizations Trading Partner User Guide for log on instructions. This guide and logon IDs are available by contacting TMHP at txmedcentraladmin@tmhp.com.

3.2. Data Submission

Encounter data is accepted 24 hours a day, 7 days a week, 365 days a year, except during brief, pre-announced maintenance periods or during regular maintenance hours on TXMedCentral (occurs every Sunday from 3 a.m. to 4 a.m. Central Standard Time (CST)).

TMHP limits encounter files to 5,000 transactions per file (multiple ST-SE segments are allowed in a single batch GS-GE) and 75 megabytes (75 mb) in file size. If a file is submitted with more than 5,000 transactions or is greater than 75 mb in file size, the entire file will be rejected and not processed by TMHP. Zipped files are preferred; however, multiple files should not be zipped together. Submitters should follow EDI standards on batching encounters by provider submissions, or other groupings (suggestions are by date of service, date of adjudication, etc).

TMHP requests the following delimiters:

- Sub Element is denoted with colon (:)
- Element is denoted with asterisks (*)
- Segment is denoted with tilde (~)
- Repetition Separator is denoted with pipe (|)

The file naming convention for encounter files will be structured as ENCFIDJJJA:

ENC is constant
F = Format (P = Professional)
ID = Plan code (MTOs that have multiple plan codes may use **one** of their plan codes in the file name since each unique encounter transaction will identify the plan code in which the client is assigned.)
JJJ = Julian Date
A = Daily Sequence (This will allow for multiple submissions per day, particularly if an MTO wishes to keep sub-contractor files separate from their own encounter files. For example, if you send two files in a given day, the first file will end with “A” and the second file will end with “B”.)

Examples: ENCP7X001A.txt ENCP9X001B.dat ENCP9X001B.zip

NOTE: File names must follow the naming convention, must not contain spaces, and must include a file extension. ONLY txt, dat and zip file extensions are allowed.

3.3. Data Element Formatting

Date formats for X12 transactions are always formatted CCYYMMDD:

CC must = 18, 19 or 20
YY must = 00-99
MM must = 01-12
DD must = 01-31 if MM = 01, 03, 05, 07, 08, 10 or 12
DD must = 01-30 if MM = 04, 06, 09 or 11
DD must = 01-28 or 01-29 if MM = 02

Numeric values are always right-justified and zero filled. Unless otherwise specified, alphanumeric values are left-justified, blank filled, and uppercase.

Signed values (ending alpha characters to denote positive or negative values) are never allowed on dollar amounts.

Negative values are only allowed on billed amounts (2300 CLM02), never on paid amounts.

For dollar amounts, X12 standards always assume a whole dollar amount unless a decimal is present. If the decimal value is zero, the decimal should not be submitted.

Examples: 125 = $125.00
125.99 = $125.99
125.9 = $125.90

Dashes, number signs, and percent signs are not allowed. Special characters that are used as segment terminators, field and composite delimiters are not allowed. Dashes from ICN numbers, tax ID numbers and Social Security Numbers must be removed.

3.4. Response Files

A series of response files will be generated after an 837 file is transmitted to TMHP.

Batch ID Acknowledgment File:

Almost immediately following the submission, TMHP will return a batch identification (BID) file. This file will be empty; it simply returns the TMHP unique file identification number number (Batch ID) that will be used to track all the response files associated with the submitted data file. It is not necessary to download this file.

The format of the BID file name is SubmitterID.TMHPFileID.MTOFileName.BID.

Submitter ID
TMHP File ID
Submitted file name
BID extension

Example: **645999999.G016BDKJ.ENCPMX110A.BID**:

Submitter	TMHP file/batch name	Submitter's file name/ID	Extension
645999999	G016BDKJ	ENCP11100A	BID

The TMHP Batch ID will be used as the tracking number, and will be assigned to every response file associated with the submitted file. When making inquiries to TMHP, it's helpful to reference the TMHP batch ID name.

TA1 File

A **TA1 file** is returned when errors exist at the Interchange level (ISA/IEA file level). An error at this level will cause the entire file to be rejected with no further processing. A TA1 will be returned if a "1" is submitted in the ISA14 field of the 837P. The most common occurrence is submitting a production file in the test environment and vice versa, without changing the Receiver ID in ISA08.

Example: **645999999.G016BDKJ.TA1**

Submitter ID	TMHP file name/Batch ID	Extension
645999999	G016BDKJ	TA1

999 File

The **999** response file checks the GS/GE segments in the file and the data content within these segments. The 999 can state the following: Accepted, Accepted with Errors or Rejected. A 999 will be created for all files no matter of its status.

Example: **645999999.G016BDKJ.999**

Submitter ID	TMHP file name/Batch ID	Extension
645999999	G016BDKJ	999

277CA File

The 277CA response file will be returned for files that pass file-level validation. The 277CA checks the ST-SE segments in the file, and notifies the submitter of the status of all transactions in the data file, as well as the results of HIPAA and business editing.

The TRN02 element in the 277CA response file will return the MTO assigned ICN.

The STC01 element will identify whether the transactions set no errors (A2 qualifier), set fatal errors (A3 qualifier), and/or set warning edits (R3 qualifier). The STC04 element will show whether the transaction accepted (WQ qualifier) or rejected (U qualifier). If a single fatal edit sets, the transaction will reject.

HIPAA edits begin with "0x", while the TMHP established business edit error messages begin with "Mx". The HHSC expects MTOs to review all response files, correct edit failures (where possible) and resubmit the transaction.

Example: **645999999.G016BDKJ.277CA**

Submitter ID	TMHP file name/Batch ID	Extension
645999999	G016BDKJ	277CA

4. Provider Information

4.1. Provider Scenarios

Below are provider scenarios corresponding to types of service which MTOs may submit on the 837 Professional MTO transactions.

This table identifies the provider types and the corresponding loop.

Provider Type	Loop
Billing Provider	2000A, 2010AA
Healthcare Provider	2310C
Performing Provider	2310B

Scenario 1 - MTO Transportation using an MTO vehicle							
Provider on Encounter	Provider Name	Plan Code	NPI/API/MTI	Taxonomy	Tax ID	DL#	Proc Code
Billing	XYZ Transportation	MX	1987654320	343800000X	111111111		A0100
Healthcare	ABC Hospital		1234567890	282N00000X	222222222		
Performing	MTO Driver		TMX0001235			DL223456	

In Scenario 1, XYZ Transportation, is the billing provider. The performing provider is the MTO's driver. The Healthcare provider will be submitted as ABC Hospital.

Scenario 2 - Meals							
Provider on Encounter	Provider Name	Plan Code	NPI/API/MTI	Taxonomy	Tax ID	DL#	Proc Code
Billing	Meals Inc	MX	TMX4567891	174200000X	111111111		A0190
Healthcare	ABC Hospital		1234567890	282N00000X	222222222		
Performing	None						

In Scenario 2, Meals Inc is both the billing and performing provider; therefore only the billing provider segment is submitted. The Healthcare provider will be submitted as ABC Hospital.

Scenario 2a – Advanced Funds Meals							
Provider on Encounter	Provider Name	Plan Code	NPI/API/MTI	Taxonomy	Tax ID	DL#	Proc Code
Billing	MTO Meals	MX	TMX1987654	174200000X	111111111		A0190
Healthcare	ABC Hospital		1234567890	282N00000X	222222222		
Performing	None						

In Scenario 2a, MTO Meals is both the billing and performing provider; therefore only the billing provider segment is submitted. The Healthcare provider will be submitted as ABC Hospital. When submitting encounters for Advanced Funds Meals, the Payment Method Code submitted must be **AF.**

Scenario 3 - Lodging							
Provider on Encounter	Provider Name	Plan Code	NPI/API/MTI	Taxonomy	Tax ID	DL#	Proc Code
Billing	Hotels Ltd	MX	TMX4567891	177F00000X	111111111		A0180
Healthcare	ABC Hospital		1234567890	282N00000X	22222222		
Performing	None						

In Scenario 3, Hotels Ltd is both the billing and performing provider; therefore only the billing provider segment is submitted. The Healthcare provider will be submitted as ABC Hospital.

Scenario 3a – Advanced Funds Lodging							
Provider on Encounter	Provider Name	Plan Code	NPI/API/MTI	Taxonomy	Tax ID	DL#	Proc Code
Billing	MTO Lodging	MX	TMX1987654	177F00000X	111111111		A0180
Healthcare	ABC Hospital		1234567890	282N00000X	22222222		
Performing	None						

In Scenario 3a, MTO Lodging is both the billing and performing provider; therefore only the billing provider segment is submitted. The Healthcare provider will be submitted as ABC Hospital. When submitting encounters for Advanced Funds Lodging, the Payment Method Code submitted must be AF.

Scenario 4a- ITP - Self							
Provider on Encounter	Provider Name	Plan Code	NPI/API/MTI	Taxonomy	Tax ID	DL#	Proc Code
Billing	ITP	MX	TMV3216545	347C00000X	111111111	DL123456	A0090
Healthcare	ABC Hospital		1234567890	282N00000X	222222222		
Performing	None						

In Scenario 4a, the MTO is PQR Transportation. The vehicle was provided by the individual or a family member. The ITP is both the Billing and Performing provider, and the driver's license number will be captured with the Billing provider information; no Performing provider information needs to be submitted. The Healthcare provider will be submitted as, ABC Hospital, for the medical provider.

Scenario 4b- ITP - Other							
Provider on Encounter	Provider Name	Plan Code	NPI/API/MTI	Taxonomy	Tax ID	DL#	Proc Code
Billing	ITP	MX	TMV3216545	347C00000X	111111111	DL234567	A0080
Healthcare	ABC Hospital		1234567890	282N00000X	222222222		
Performing	None						

In Scenario 4b, the MTO is PQR Transportation. The vehicle was provided by a volunteer. The volunteer is both the Billing and Performing provider, and the driver's license number will be captured with the Billing provider information; no Performing provider information needs to be submitted. The Healthcare provider will be submitted as, ABC Hospital, for the medical provider.

In Scenarios 4a and 4b, when an ITP encounter is for Advanced Funds Mileage, the Payment Method Code submitted must be **AF**.

Scenario 5- Airline Travel							
Provider on Encounter	Provider Name	Plan Code	NPI/API/MTI	Taxonomy	Tax ID	DL#	Proc Code
Billing	ABC Air	MX	TMZ456786	344800000X	111111111		A0140
Healthcare	ABC Hospital		1234567890	282N00000X	222222222		
Performing	None						

In Scenario 5, ABC Air both the billing and performing provider; therefore only the billing provider segment is submitted. The Healthcare provider will be submitted as, ABC Hospital, for the medical provider.

Scenario 6- Demand Response							
Provider on Encounter	Provider Name	Plan Code	NPI/API/MTI	Taxonomy	Tax ID	DL#	Proc Code
Billing	Cab Inc	MX	A123456789	343800000X	111111111		A0100
Healthcare	ABC Hospital		1234567890	282N00000X	222222222		
Performing	Taxi Driver	MX	TMZ0001234			DL654321	

In Scenario 6, Cab Inc, a taxi service, is the billing provider. The Healthcare provider will be submitted as, ABC Hospital, for the medical provider. The Performing Provider is the taxi driver and a driver's license number is required.

Scenario 7 - Mass Transit							
Provider on Encounter	Description	Plan Code	NPI/API/MTI	Taxonomy	Tax ID	DL#	Proc Code
Billing	Mass Transit Inc	MX	A123456789	347B00000X	111111111		T2004
Healthcare	ABC Hospital		1234567890	282N00000X	222222222		
Performing	None						

In Scenario 7, Mass Transit Inc is both the billing and performing provider; therefore only the billing provider segment is submitted. The Healthcare provider will be submitted as, ABC Hospital, for the medical provider.

4.2. Provider Validation

The MTO Provider Network File (MT88) provides a listing of the Medical Transportation Providers and Participants contracting with each MTO. Each MTO will deliver this file bi-weekly, via TXMedCentral. A separate file must be delivered for each Region. This information will be used to validate provider data in the encounters submitted by the MTOs.

TMHP will compare the Date of Service (Travel Date) submitted in the 837P Encounter file, to the Provider's Network Effective Date and Termination Date for the Plan Code submitted. If either the billin or the performing provider was not active in the plan on the Travel Date, the transaction will be rejected. Refer to Section 8.3 and Appendix B for all provider validation edits.

5. Adjustments

5.1. Overview

The fundamental purpose for collecting encounter data is to have the most accurate data representation of all services provided to an individual by an MTO. For the majority of transactions, the original record is the most accurate representation. For the remainder of the transactions, the original record needs to be updated in order to be accurate. In the TMHP environment, updates are referred to as "adjustments". The reasons for adjustments vary, some being:

- compensation changes,
- audit findings,
- eligibility and enrollment changes, and
- re-adjudication of the claim.

All MTOs perform adjustments to transactions. Frequently, a single adjustment is all that is required to produce the most accurate representation of the service provided. However, there are instances when multiple adjustments are required.

TMHP expects MTOs to submit original transactions, as well as adjustment transactions. If adjustments are not submitted, the TMHP data warehouse will not be accurate data representation of a MTO's efforts, which could adversely affect a MTO in the areas of outcomes measures, utilization, compensation and contracting.

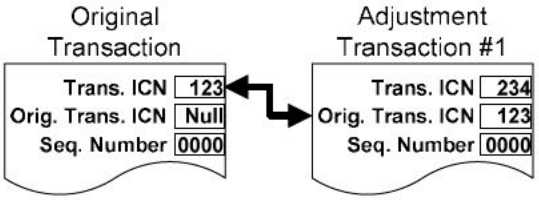
The use of a HIPAA-compliant transaction mandates that, when an adjustment to a previously submitted transaction is necessary, the entire transaction must be submitted; line item adjustments are prohibited.

TMHP will process the transaction as an adjustment when the Claim Frequency Code submitted is "7".In order to maintain an accurate data representation, a sequencing process is required in order to associate an adjustment transaction to a previously submitted transaction using the MTO assigned ICN.

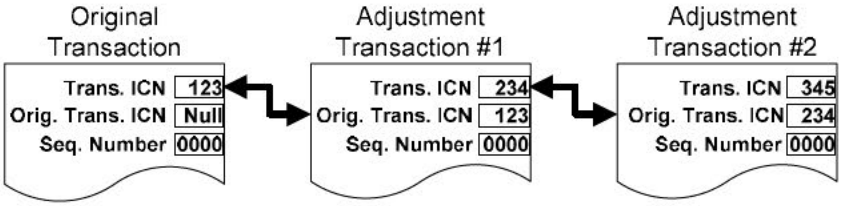
5.2. The Daisy-Chain Process

The daisy-chain process associates an adjustment transaction to the most recent iteration of an original transaction. A 3-part daisy-chain process example is provided.

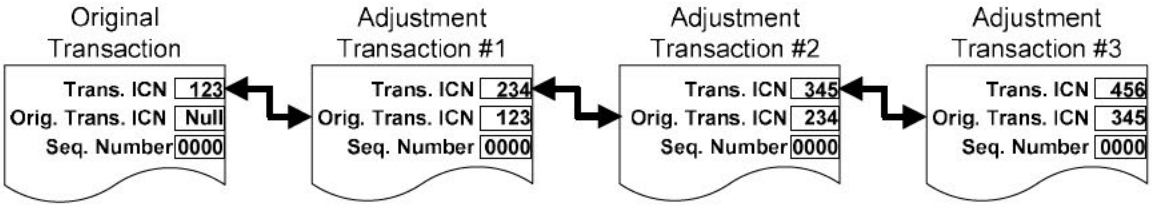
Part 1. A MTO adjusts an original transaction with an adjustment transaction. The association is possible because the adjustment transaction contains the original transaction ICN.



Part 2. At a later point in time, a second adjustment is necessary, so a second adjustment transaction is produced. The association is possible because the second adjustment transaction contains the ICN of the first adjustment transaction. The second adjustment transaction contains no reference to the original transaction.



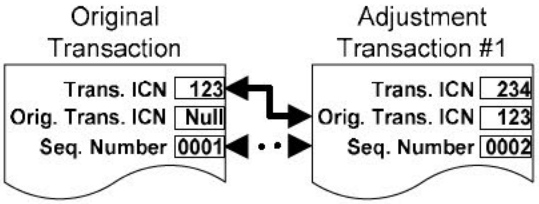
Part 3. If a third adjustment transaction is necessary, the third adjustment transaction contains the ICN of the second adjustment transaction. Neither the second adjustment transaction nor third adjustment transaction contains a reference to the original transaction. This process can be repeated as many times as necessary to ensure the most accurate representation of the healthcare instance.



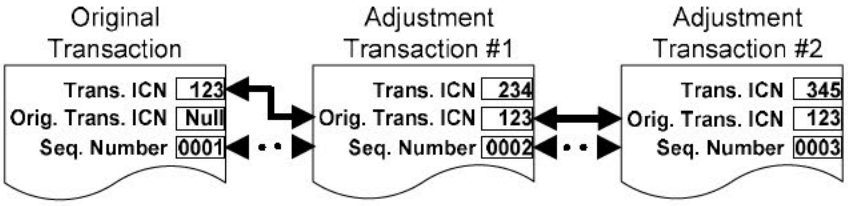
5.3. The Sequence Process

The sequence process associates all adjustment transactions to the original transaction by using the original transaction ICN. The order of the adjustment transactions is maintained by using a sequence number. A 3-part sequence process example is provided.

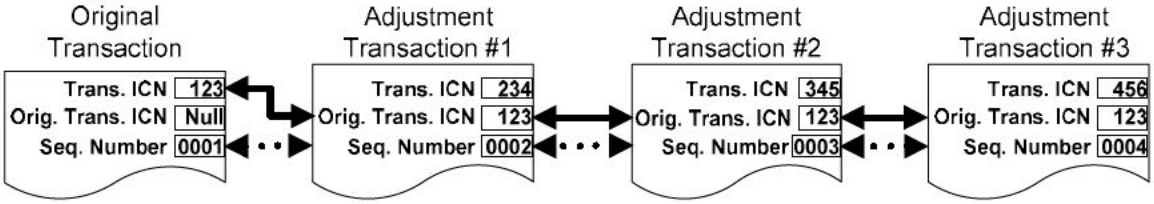
Part 1. An MTO adjusts an original transaction with an adjustment transaction. The association is possible because the original transaction ICN (123) as well as a sequence number (0001) are placed on the adjustment transaction.



Part 2. If a second adjustment transaction is used, the original transaction ICN (123) as well as the next sequence number (0002) are placed on the second adjustment transaction. There is no direct reference to the first adjustment transaction.



Part 3. If a third adjustment transaction is used, the original transaction ICN (123) as well as the next sequence number (0003) are placed on the third adjustment transaction. There is no direct reference to the first adjustment transaction or the second adjustment transaction.



Note: Some organizations apply a sequence number of (0000) to the original. In this case, the first adjustment record's sequence number will be (0001). This poses no problem to the encounter adjustment process.

5.4. HIPAA Component in the Adjustment Process

As stated earlier, any adjustment requires the re-submission of the entire transaction. The four values below are used to process encounter adjustments. The name and the location of the listed values are the same for all 837P transactions.

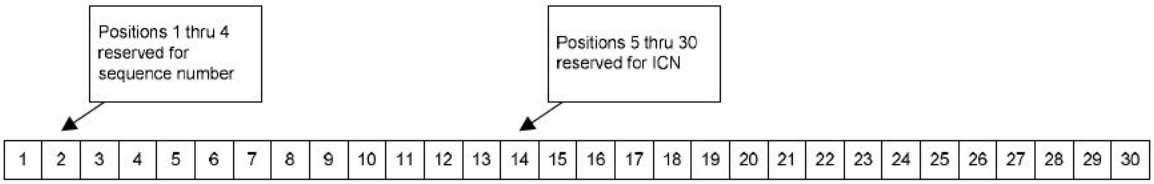
MTO Plan Code:
- Loop: 2330B
- Segment: NM1
- Reference Description: NM108 = "PI"
- Reference Description: NM109 = [Plan Code]

Transaction ICN of the encounter being adjusted:
- Loop: 2300
- Segment: REF
- Reference Description: REF01 = "F8"
- Reference Description: REF02 = [Original Transaction ICN]

Transaction ICN of the adjustment transaction being submitted:
- Loop: 2330B
- Segment: REF
- Reference Description: REF01 = "F8"
- Reference Description: REF02 = [Transaction ICN]

Claim Frequency Code (must be "7" for adjustment transactions):
- Loop: 2300
- Segment: CLM
- Reference Description: CLM05-3

REF02 may contain up to 30 characters (no spaces). Since there is no existing location for a sequence number on an 837 transaction, the first four positions of REF02 will be reserved for sequence numbers. If an MTO does not use sequence numbers in their adjustment process, the first four positions will be filled with zeros (0000). This approach also means an MTO's [Transaction ICN] may not exceed 26 characters. The same rules apply for REF02 used to store the Tranaction ICN of the encounter being adjusted.



NOTE: Regardless of which method the MTO uses, the 4 digit sequence number positions must be filled with either a true sequence ID or a place holder, e.g., "0000" or "0001".

6. Voids

6.1. Overview

At times, it may be necessary to void an encounter or several encounters or an entire file of encounters. Voids might be required because the MTO has submitted an encounter to TMHP in error.

TMHP will process the transaction as a Void when the Claim Frequency Code submitted is "8".

In order to process the transaction correctly, the submitter must:

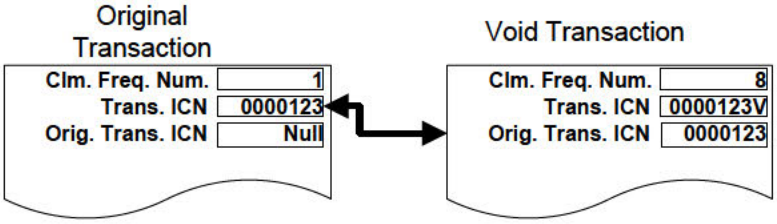
- Identify the ICN of the transaction being voided (including the sequence number)
- Assign a new, unique ICN to the Void transaction.
  Any method of identification can be used, as long as the new ICN is unique.
  A recommended method is to add a "V" to the end of the ICN being voided.

The void transaction will reject if:

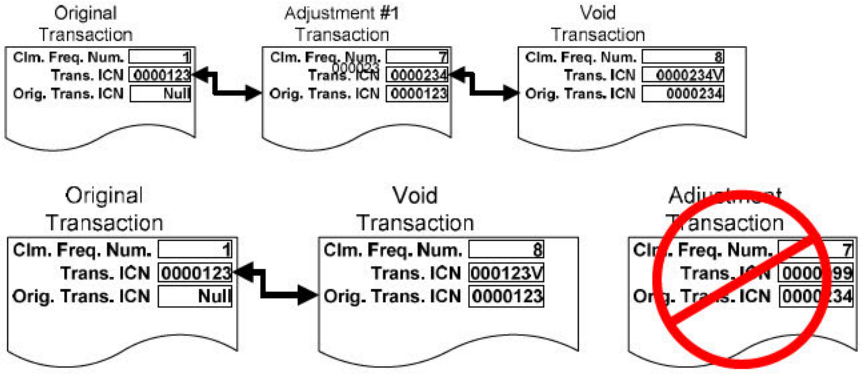
- The Void transaction does not have a new, unique ICN
- The plan code + the ICN (including the sequence number) of the transaction being voided is not found in the system.

Denied claims may not be adjusted. Previously voided encounters and original paid encounters that have been adjusted may not be voided. If a transaction has been adjusted, the submitter may void the adjustment ICN only.

6.2. Original to Void



6.3. Original, Adjustment to Void



6.4. HIPAA Component in the Void Process

As stated earlier, any void requires the re-submission of the entire transaction. The four values below are used to process encounter voids. The name and the location of the listed values are the same for all 837P transactions. The values are:

MTO Plan Code:
- Loop: 2330B
- Segment: NM1
- Reference Description: NM108 = “PI”
- Reference Description: NM109 = [Plan Code]

Tranaction ICN of the encounter being voided:
- Loop: 2300
- Segment: REF
- Reference Description: REF01 = “F8”
- Reference Description: REF02 = [Original Transaction ICN]

Transaction ICN of the void transaction being submitted:
- Loop: 2330B
- Segment: REF
- Reference Description: REF01 = “F8”
- Reference Description: REF02 = [Transaction ICN]

Claim Frequency Code (must be “8” for void transactions):
- Loop: 2300
- Segment: CLM
- Reference Description: CLM05-3

For information on sequencing, refer to Section 5.3.

7. Units and Attendants

Encounter data associated with billed units, paid amounts, and attendants must be reported consistently by all MTOs to support HHSC's analyses, outcomes measures, utilization, compensation and contracting. The following is provided to assist MTOs in correctly reporting these values in the encounter transactions submitted.

7.1. Meals

Provider Specialty	Definition	Taxonomy	Procedure Code
T8 - Meals	Hospital cafeterias or other meal providers	174200000X Meals, Other Service Providers	A0190 Non-emergency transportation: ancillary: meals-recipient

Submission Instructions:

- Each client must be submitted on a separate encounter
- 1 unit = 1 meal day
- Max 1 week of meals per encounter
- For meals, there will always be an attendant
- The number of units must never be greater than 7 x the number of travelers
- Additional amounts/units for attendants are submitted on the client's encounter
- When there is one attendant for multiple clients, additional amounts/units for the attendant are only added to the first encounter
- When there are multiple attendants for multiple clients (i.e. Two parents for two children), one attendant is recorded on each encounter
- Shared services identified by common shared services reference id (i.e. Invoice number) on each encounter when an attendant is shared by two clients

Examples:

Scenario	Paid Amount (2320 AMT02)	# Units (2400 SV104)	If Attendants, # Recipients (2400 QTY02)	Shared Services Ref ID (2300 NTE02)
1 Meal Day for 1 Client and 1 Attendant	$50	2	2	Not applicable do not submit
7 Meal Days for 1 Client and 2 Attendants	$525	21	3	Not applicable do not submit
1 Meal Day for 2 Clients and 1 Attendant				
• 1st Client submitted on one Encounter • Amount/Units for Attendant only added to 1st Encounter	$50	2	2	A123456789
• 2nd Client submitted on separate Encounter • Reflect Attendant but without Amount/Units on 2nd Encounter	$25	1	2	A123456789
1 Meal Day for 2 Clients and 2 Attendants				
• 1st Client submitted on one Encounter with one Attendant	$50	2	2	Not applicable do not submit
• 2nd Client submitted on separate	$50	2	2	Not applicable

Encounter with other Attendant				do not submit

7.2. Lodging

Provider Specialty	Definition	Taxonomy	Procedure Code
T6 - Lodging	Hotels and other lodging providers	177F00000X Lodging, Other Service Providers	A0180 Non-emergency transportation: ancillary: lodging-recipient

Submission instructions:

- Each client must be submitted on a separate encounter
- 1 unit = 1 room per night
- Max 1 week of rooms per encounter
- For lodging, there will always be an attendant
- Additional amounts/units for attendants are submitted on the client's encounter
- When there are shared services (i.e. Two clients sharing one room), enter total paid amount of first encounter and $0 on subsequent encounters.
- Shared services identified by common shared services reference id (i.e. Invoice number) on each encounter

Examples:

Scenario	Paid Amount (2320 AMT02)	# Units (2400 SV104)	If Attendants, # Recipients (2400 QTY02)	Shared Services Ref ID (2300 NTE02)
1 Room for 1 Night with 1 Attendant @ $100 per room per night	$100	1	2	Not applicable do not submit
1 Room for 7 Nights with 2 Attendant @ $100 per room per night	$700	7	3	Not applicable do not submit
1 Room for 7 Nights shared by 2 Clients with 1 Attendant @ $100 per room per night				
• 1st Client submitted on one Encounter • Total Amount entered on 1st Encounter • Common Shared Service Reference ID entered on each Encounter	$700	7	2	A123456789
• 2nd Client submitted on separate Encounter • $0 entered on 2nd Encounter	$0	0	2	A123456789

7.3. Airline Travel

Provider Specialty	Definition	Taxonomy	Procedure Code
T2 - Airline Travel	American, Delta and other airline providers	344800000X Air Carrier, Transportation Services	A0140 Non-emergency transportation and air travel (private or commercial) intra or inter state

Submission instructions:

- Each client must be submitted on a separate encounter
- Each trip must be submitted on a separate encounter (one-way or round-trip)
- 1 unit = 1 mile (number of units = total miles of trip)
- Additional paid amounts for attendants are submitted on the client's encounter, but the number of units (total miles of trip) should not be changed
- Shared services identified by common shared services reference id (i.e. Invoice number) on each encounter when an attendant is shared by two clients

Examples:

Scenario	Paid Amount (2320 AMT02)	# Units (2400 SV104)	If Attendants, # Recipients (2400 QTY02)	Shared Services Ref ID (2300 NTE02)
1 Trip of 500 Miles for 1 Client with No Attendants @ $250 per ticket	$250	500	Not applicable do not send	Not applicable do not submit
1 Trip of 500 Miles for 1 Client with 1 Attendant @ $250 per ticket	$500	500	2	Not applicable do not submit
2 Trips of 500 Miles each for 1 Client with 1 Attendant @ $250 per ticket				
• 1st Trip submitted on one Encounter	$500	500	2	Not applicable do not submit
• 2nd Trip submitted on separate Encounter	$500	500	2	Not applicable do not submit
1 Trip of 500 Miles for 2 Clients with 1 Attendant @ $250 per ticket				
• 1st Client submitted on one Encounter • Amount for Attendant only added to 1st Encounter	$500	500	2	A123456789
• 2nd Client submitted on separate Encounter	$250	500	2	A123456789

7.4. Intercity Bus and Mass Transit

Provider Specialty	Definition	Taxonomy	Procedure Code
T3 - Intercity Bus (Greyhound)	Greyhound, Megabus and other intercity bus transportation providers	347B00000X Bus, Transportation Services	A0110 Non-emergency transportation and bus, intra or interstate carrier
T7 - Mass Transit	DART (Dallas), METRO (Houston) and other public transportation providers, either publicly or privately owned, that provide general or special service transportation to the public on a regular and continuing basis	347B00000X Bus, Transportation Services	T2004 Non-emergency transport; commercial carrier, multi-pass

Submission Instructions:

- Each client must be submitted on a separate encounter
- Each leg must be submitted on a separate encounter
- 1 unit = 1 mile (number of units = total miles of leg)
- Additional paid amounts for attendants are submitted on the client's encounter, but the number of units (total miles of leg) should not be changed
- Shared services identified by common shared services reference id (i.e. Invoice number) on each encounter when an attendant is shared by two clients

Examples:

Scenario	Paid Amount (2320 AMT02)	# Units (2400 SV104)	If Attendants, # Recipients (2400 QTY02)	Shared Services Ref ID (2300 NTE02)
1 Leg of 100 Miles for 1 Client with No Attendants @ $50 per fare	$50	100	Not applicable do not send	Not applicable do not submit
1 Leg of 100 Miles for 1 Client with 1 Attendant @ $50 per fare	$100	100	2	Not applicable do not submit
2 Legs of 100 Miles each for 1 Client with 1 Attendant @ $50 per fare				
• 1st Leg submitted on one Encounter	$100	100	2	Not applicable do not submit
• 2nd Leg submitted on separate Encounter	$100	100	2	Not applicable do not submit
1 Leg of 100 Miles for 2 Clients with 1 Attendant @ $50 per fare				
• 1st Client submitted on one Encounter • Amount for Attendant only added to 1st Encounter	$100	100	2	A123456789
• 2nd Client submitted on separate Encounter	$50	100	2	A123456789

7.5. Individual Transportation Provider (ITP)

Provider Specialty	Definition	Taxonomy	Procedure Code
T4 - Individual Transportation Participant (ITP) Self	Individuals that provide rides to Medicaid-related health visits for themselves or an immediate family member	347C00000X Private Vehicle, Transportation Services	A0090 Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest.
T4 - Individual Transportation Participant (ITP) Other	Individuals that provide rides to Medicaid-related health visits for someone other than themselves or an immediate family member	347C00000X Private Vehicle, Transportation Services	A0080 Non-emergency transportation, per mile - vehicle provided by volunteer (individual or organi-zation), with no vested interest

Submission Instructions:

- Each client must be submitted on a separate encounter

- Each leg must be submitted on a separate encounter
- 1 unit = 1 mile (number of units = total miles of leg)
- Additional paid amounts for attendants submitted on the client's encounter, but the number of units (total miles of leg) should not be changed
- When there are shared services (i.e. Two clients sharing one ride), enter total paid amount of first encounter and $0 on subsequent encounters.
- Shared services identified by common shared services reference id (i.e. Invoice number) on each encounter

Examples:

Scenario	Paid Amount (2320 AMT02)	# Units (2400 SV104)	If Attendants, # Recipients (2400 QTY02)	Shared Services Ref ID (2300 NTE02)
1 Leg of 10 Miles for 1 Client with No Attendants @ $0.56 per mile	$5.60	10	Not applicable do not send	Not applicable do not submit
1 Leg of 10 Miles for 1 Client with 1 Attendant @ $0.56 per mile for 2 passengers	$5.60	10	2	Not applicable do not submit
2 Legs of 10 Miles each for 1 Client with 1 Attendant @ $0.56 per mile				
• 1st Leg submitted on one Encounter	$5.60	10	2	Not applicable do not submit
• 2nd Leg submitted on separate Encounter	$5.60	10	2	Not applicable do not submit
1 Leg of 10 Miles for 2 Clients with 1 Attendant @ $0.56 per mile				
• 1st Client submitted on one Encounter • Total Amount entered on 1st Encounter • Common Shared Service Reference ID entered on each Encounter	$5.60	10	2	T123456789
• 2nd Client submitted on separate Encounter • $0 entered on 2nd Encounter	$0	0	2	T123456789

7.6. Demand Response

Provider Specialty	Definition	Taxonomy	Procedure Code
TR - Managed Transportation Organization Demand Response MTO Waiver	MTO that provides demand response transportation services using their own fleet per an approved Texas HHSC waiver	343800000X Secured Medical Transport (VAN), Transportation Services	A0100 Non-emergency transportation, taxi

Provider Specialty	Definition	Taxonomy	Procedure Code
TZ - Managed Transportation Organization Demand Response MTO Driver Waiver	Driver working for an MTO that provides demand response transportation services using their own fleet per an approved Texas HHSC waiver	343800000X Secured Medical Transport (VAN), Transportation Services	A0100 Non-emergency transportation, taxi
TS - Demand Response Subcontractor	Company contracted by an MTO to provide demand response transportation services	343800000X Secured Medical Transport (VAN), Transportation Services	A0100 Non-emergency transportation, taxi
TD - Demand Response Subcontractor Driver	Driver working for an MTO Subcontractor providing demand response transportation services	343800000X Secured Medical Transport (VAN), Transportation Services	A0100 Non-emergency transportation, taxi

Submission Instructions:

- Each client must be submitted on a separate encounter
- Each leg must be submitted on a separate encounter
- 1 unit = 1 mile (number of units = total miles of leg)
- Additional paid amounts for attendants submitted on the client's encounter, but the number of units (total miles of leg) should not be changed
- Shared services identified by common shared services reference id (i.e. Invoice number) on each encounter

Examples:

Scenario	Paid Amount (2320 AMT02)	# Units (2400 SV104)	If Attendants, # Recipients (2400 QTY02)	Shared Services Ref ID (2300 NTE02)
1 Leg of 10 Miles for 1 Client with No Attendants @ $30 fare	$30	10	Not applicable do not send	Not applicable do not send
1 Leg of 10 Miles for 1 Client with 1 Attendant @ $45 fare for 2 passengers	$45	10	2	Not applicable do not submit
2 Legs of 10 Miles each for 1 Client with 1 Attendant @ $45 fare for 2 passengers				
• 1st Leg submitted on one Encounter	$45	10	2	Not applicable do not submit
• 2nd Leg submitted on separate Encounter	$45	10	2	Not applicable do not submit
1 Leg of 10 Miles for 2 Clients with 1 Attendant @ $15 per fare for 3 passengers				
• 1st Client submitted on one Encounter • Amount for Attendant only added to 1st Encounter • Common Shared Service Reference ID entered on each Encounter	$30	10	2	T123456789
• 2nd Client submitted on separate Encounter •	$15	10	2	T123456789

8. Encounter Transaction Editing

8.1. Overview

All encounter data transaction files submitted to TMHP will be validated Two layers of validation are performed on Encounters transactions. HIPAA validation is performed to ensure compliance with the ASC X12 HIPAA format. Transactions which do not pass this layer of validation will be rejected. Transactions which pass will then be processed for Business validation. Transactions that pass this business validation process will be accepted by TMHP systems. HIPAA validation of Encounters transactions utilizes the Strategic National Implementation Process (SNIP) Levels 1, 2, 3, 4, 6 and 7.

HHSC expects MTOs to submit all transactions, regardless of final disposition (approved/paid vs. denied/not paid). The MTOs are to submit all adjudicated claims regardless of disposition. HHSC has assembled a set of edits that are well suited for encounters. Some edits will cause a record rejection while other edits will allow the record to be accepted, while providing feedback to the MTO about the record and the reason for the edit failure.

HHSC may have a business need to change an edit from warning to fatal (or vice versa) in the future. The change may occur because of unanticipated data quality issues. HHSC will communicate its' intent to the MTOs prior to implementing a change.

8.2. Edit Classifications

Edits are classified as fatal or warning. Fatal edits result in the rejection of a transaction, while warning edits allow the transaction to be accepted, but logged and reported within TMHP systems and in the 277CA MTO response file.

- Fatal Error (A3)
  - The record is rejected by TMHP.
  - The edit failure is reported to the MTO by TMHP.
  - TMHP expects the MTO to correct the fatal error and resubmit the encounter transaction.
  - The record remains outside of the data warehouse, thus preventing it from being used for analysis.

- Warning Error (R3)
  - The record is accepted by TMHP.
  - The edit warning is reported to the MTO by TMHP.
  - The MTO has the option of re-submitting an adjustment encounter transaction.

8.3. Business Edits

The following edits support critical business requirements:

BUS Edit MX0000001	MTO Plan Code must be active on the date of service.	Fatal Edit

Explanation: The MTO Plan Code (2330B NM109) must be active on the date of service (2300 DTP03) submitted. If the Date of Service is less than the Plan Effective Date, or greater than the Plan Termination Date, the encounter will be rejected.

BUS Edit MX0000002	Billing Provider submitted must be active in this plan on the date of service.	Fatal Edit

Explanation: The MTO may only submit Billing Providers that are approved MTO providers. This edit will be set if the Billing Provider is not an active MTO provider on the date of service. [if NPI: 2010AA NM109; if API/MTI: 2010BB REF02] (Does not apply to submission of VOIDS)

BUS Edit MX0000003	Authorization Number is required.	Fatal Edit

Explanation: The MTO must submit the authorization for the service provided. This edit will be set if no authorization number (2300 REF02) is submitted.

BUS Edit MX0000004	Procedure Code must be a value valid.	Fatal Edit

Explanation: The MTO must submit a valid MTO procedure code(2400 SV101-2). This edit will be triggered if the procedure code submitted is not included in the MTO procedure code list. Refer to Appendix A: MTP Procedure Code Crosswalk of the 837P MTO Companion Guide for the valid procedure code list.

BUS Edit MX0000005	Claim Date of Receipt is required	Fatal Edit

Explanation: The MTO must submit the date (2300 NTE02) the claim was received by the MTO. This edit will be set if this date is not provided.

BUS Edit MX0000006	Claim Date of Receipt must be in CCYYMMDD format.	Fatal Edit

Explanation: The MTO must submit the date (2300 NTE02) the claim was received by the MTO in CCYYMMDD format. This edit will be set if this date is not provided in this format.

BUS Edit MX0000007	Date of Service must be before the Claim Date of Receipt when encounter payment method is not Advanced Funds (AF) or Credit Card (CC)	Fatal Edit

Explanation: The Date of Service (2300 DTP03) must occur on or prior to the Claim Date of Receipt (2300 NTE02). The transaction may not be submitted prior to the date of service. This edit will apply to scenarios where the payment method is not Advanced Funds (AF) or Credit Card (CC).

BUS Edit MX0000008	Special Needs code must be a valid value.	Fatal Edit

Explanation: The MTO must submit a valid Special Needs code (2300 NTE02). This edit will be set if the Special Needs code is invalid. Refer to the Claim Note Information in the 837P MTO Companion Guide for the valid Special Needs list.

BUS Edit MX0000009	Payment Method must be a valid value.	Fatal Edit

Explanation: The MTO must submit a payment method. The payment method must be a valid value. This edit will be set if the payment method is not submitted or is not a valid value. [valid values: Advanced Funds = "AF"; Credit Card = "CC"; Direct Bill = "DB"].

BUS Edit MX0000010	Driver License Number is required and must match the driver license on file for submitted MTI.	Warning Edit

Explanation: This edit will be set if the Driver License Number (2010AA REF02 ITPs)/2310B REF02 non-ITPs) submitted is different than the Driver License Number received on the MTO Network file (MT88).

BUS Edit MX0000011	Driver License Number for submitted MTI must be active on date encounter is processed.	Warning Edit

Explanation: The Driver License Number (2010AA REF02 (ITPs)/2310B REF02 (non-ITPs)) submitted must be valid on the claim receipt date. This edit will be set if the Driver License Number submitted has a value of 'N' or 'X' for the DL Validity Indicator on the MTO Network file.

BUS Edit MX0000012	Performing Provider MTI submitted must be active in the plan for this date of service.	Fatal Edit

Explanation: The Performing Provider MTI (2310B/REF02) is not active in the MTO's plan on the date of service. The Performing Provider must be enrolled in the MTO on the date of service; otherwise this edit will be set. (Does not apply to submission of VOIDS)

BUS Edit MX0000013	Healthcare Provider NPI/API is required.	Fatal Edit

Explanation: The MTO is required to submit the NPI/API of the Healthcare Provider (NPI - 2310C NM109; API – 2310C REF02) that the client travelled to/from. This edit will be set if the NPI/API is not submitted.

BUS Edit MX0000014	Healthcare Provider taxonomy is required.	Fatal Edit

Explanation: The MTO is required to submit the provider taxonomy of the Healthcare Provider that the client travelled to/from. This edit will set if this value is not submitted or the value submitted is not a valid value.

BUS Edit MX0000015	Date of Service (Travel Date) is required.	Fatal Edit

Explanation: The MTO must submit the date of service (2300/DTP03). The date of service is the date of travel. This edit will be set if the Date of Service/Travel Date is not submitted.

BUS Edit MX0000016	Date of Service (Travel Date) must be on or after 9/1/2014.	Fatal Edit

Explanation: The MTO must submit a valid date of service (2300/DTP03). The date of service must be after 09/01/2014. This edit will be set if the Date of Service/Travel Date submitted is prior to 09/01/2014.

BUS Edit MX0000017	Origination Address is required when encounter is for travel, (airline, taxi, bus, or mileage reimbursement).	Fatal Edit

Explanation: The MTO must submit the starting address (2310E/N301, N401, N402, N403) for the trip. This edit will be set if the Origination Address is not submitted.

BUS Edit MX0000018	Destination Address is required when encounter is for travel, (airline, taxi, bus, or mileage reimbursement).	Fatal Edit

Explanation: The MTO must submit the destination address (2310F/N301, N401, N402, N403) for the trip. This edit will be set if the Destination Address is not submitted.

BUS Edit MX0000019	Number of One-Way Trips quantity is required and must be numeric.	Fatal Edit

Explanation: If the client had a one-way trip, the MTO must submit the number of one-way trips (2400/NTE02 position 2) taken. This edit will be set if the quantity of One-Way Trips is not submitted.

BUS Edit MX0000020	Subscriber less than 15 years old on date of service requires an attendant.	Fatal Edit

Explanation: If the client (subscriber) was under 15 years old on the date of service, at least one (1) attendant is required. This edit will be set if the subscriber is younger than 15 (2010BA DMG02) on the date of service and the number of attendants (2400 QTY02) is not submitted or is less than 2 (client plus attendant).

BUS Edit MX0000021	Subscriber is 15-17 years old on date of service requires an attendant when receiving non-family planning services.	Warning Edit

Explanation: If the client (subscriber) is between 15-17 years old, at least one (1) attendant must be submitted for the transaction; unless the client was receiving family planning services from the healthcare provider, is emancipated by court, or a parental consent on file . This edit will be set if the subscriber is between 15 and 17 years old (2010BA DMG02) on the date of service (2300 DTP03) and the number of attendants (2400 QTY02) is not submitted or is less than two (2) (client plus attendant).

BUS Edit MX0000022	Encounter Status Code is required and must be a valid value.	Fatal Edit

Explanation: The MTO must submit the status (2400/NTE02 position 1) of the encounter. This edit will be set if the Encounter Status Code is not submitted or an invalid value is submitted.

BUS Edit MX0000023	Paid Amount must be zero (0) when Encounter Status Code is 'D' (Denied).	Fatal Edit

Explanation: If the MTO submits an encounter status code of ‘D’ (Denied), then the amount paid must be ‘0’. This edit is set if the amount paid is greater than ‘0’. [encounter status code - 2400/NTE02 – position 1; paid amount – 2430/SVD02]

BUS Edit MX0000024	Claim Frequency Code must be '1' (Original), '7' (Adjustment), or '8' (Void).	Fatal Edit

Explanation: The MTO must submit a valid claim frequency code (2300/CLM05-3). The only claim frequency codes that are accepted are 1, 7, and 8. This edit will be set if claim frequency code is not 1, 7, or 8.

BUS Edit MX0000025	A transaction must only have one detail segment.	Fatal Edit

Explanation: The MTO may only submit one detail line (2400/LX) per claim. If multiple service lines are submitted, this edit will be set.

BUS Edit MX0000026	Adjudication Date is required.	Fatal Edit

Explanation: The MTO must submit the date the claim was adjudicated (2330B/DTP03). If no date is submitted, this edit will be set.

BUS Edit MX0000027	Adjudication Date must be on or after the Claim Receipt Date.	Warning Edit

Explanation: The Adjudication Date (2330B/DTP03) must occur on or after the Claim Date of Receipt(2300/NTE02). This edit will be set if the Adjudication Date submitted is prior to the Claim Date of Receipt.

BUS Edit MX0000028	Provider's specialty must be valid for procedure code submitted.	Fatal Edit

Explanation: This edit will be set if the provider's speciality is not valid for the procedure. Refer to Appendix A: MTP Procedure Code Values of the 837P MTO Companion Guide for the valid procedure code list. (Does not apply to submission of VOIDS)

BUS Edit MX0000029	Billing Provider Taxonomy is required.	Fatal Edit

Explanation: The Billing Provider's Taxonomy (2000A PRV03) must be submitted. If no Billing Provider Taxonomy is submitted, this edit will be set.

BUS Edit MX0000030	Submitted Subscriber PCN must be on client eligibility file.	Fatal Edit

Explanation: The MTO may only submit encounters for eligible subscribers (2010BA/NM109). This edit will set if the subscriber is not active on the date of service.

BUS Edit MX0000031	Submitted Subscriber PCN must be eligible for MTP services according to client eligibility file.	Warning Edit

Explanation: The MTO may only submit encounters for eligible subscribers (2010BA/NM109). This edit will set if the subscriber is not eligible for MTP services.

BUS Edit MX0000032	Submitted Subscriber Plan Code must match the plan code on the client eligibility file.	Warning Edit

Explanation: The plan code (2330B NM109) submitted must match the plan code for the subscriber. This edit will set if the plan code submitted does not match the subscriber's plan code.

BUS Edit MX0000033	An encounter transaction may only be submitted once.	Fatal Edit

Explanation: Transactions must have a unique "Plan Code+ sequence number+ICN+" (2330B REF02). This edit will set if the transaction number submitted has already been submitted regardless of claim frequency. Refer to Section 5.3 for information on sequencing.

BUS Edit MX0000034	Original ICN must be submitted for an adjusted or voided claim.	Fatal Edit

Explanation: When an adjustment or void is submitted (claim frequency "7" or "8" at 2300 CLM05-03), the transaction being adjusted or voided (original ICN at 2300 REF02) must have been submitted prior to the adjustment. This edit will set if the prior transaction number is not found in the system when the adjustement or void is processed. Refer to Section 5 for information on adjustments, and Section 6 for information on voids.

BUS Edit MX0000035	ICN must never have been previously adjusted or voided.	Fatal Edit

Explanation: ICNs (original ICN – 2300 REF02) that have been previously voided or adjusted are marked so that no further action will be taken on that ICN. Adjustments and voids must be associated with a previous transaction that has not already been adjusted or voided. This edit will set if the original transaction number has not been previously voided or adjusted. Refer to Section 5 for information on adjustments and Section 6 for information on voids.

BUS Edit MX0000036	Submitter ID must match Sender ID.	Fatal Edit

Explanation: The Sender ID (ISA06) must match the Submitter ID (1000A NM109).

BUS Edit MX0000037	Billing provider taxonomy must be a valid value.	Fatal Edit

Explanation: This edit will set when a billing provider taxonomy that is not associated with the MTP program is submitted in the X12 837P encounter transaction; it will also set when taxonomy code '347E00000X' (which is aligned to MTP Provider Specialty code 'TT' – Broker) is submitted.

BUS Edit MX0000038	Lodging units cannot exceed 7 days per encounter.	Fatal Edit

Explanation: The maximum allowed number of units for a lodging encounter is 7 calendar days. This edit will set when the billed units (2400 SV104) exceed 7 calendar days and the procedure code (2400 SV101-2) is "A0180" for lodging services.

BUS Edit MX0000039	Meal units cannot exceed 7 meal days per recipient per encounter.	Fatal Edit

Explanation: The maximum allowed number of units for a meals encounter is 7 meal days for the number of travelers reported on the encounter. This edit will set when the billed units (2400 SV104) exceed 7 X the number of travelers (2400 QTY02), and the procedure code (2400 SV101-2) is "A0190" for meals services. See Section 7.1 for examples.

BUS Edit MX0000040	Meal paid amount cannot exceed the MTP allowed amount.	Fatal Edit

Explanation: The paid amount for Meals is $25 per meal day. This edit will set when the header paid amount (2320 AMT02) exceeds the allowed amount times the number of billed units (2400 SV104), and the procedure code (2400 SV101-2) is “A0190” for meals services.

BUS Edit MX0000041	Mileage reimbursement to ITPs must equal the MTP allowed amount	Fatal Edit

Explanation: The allowed mileage reimbursement to an ITP is $0.535 per mile as of 1/1/2017*. This edit will set when the header paid amount (2320 AMT02) does not equal the allowed rate times the number of units (2400 SV104) when the procedure code (2400 SV101-2) is “A0080” or “A0090” for ITP mileage services.

*For encounters with date of service from 9/1/2014 – 12/31/2015, the allowed mileage reimbursement to an ITP was $0.56 per mile.
*For encounters with date of service from 1/1/2016 – 12/31/2016, the allowed mileage reimbursement to an ITP was $0.54 per mile

To evaluate and verify the Paid Amt submitted on each ITP encounter, TMHP will multiply the Billed Units x Rate Per Mile, and round the resulting dollar amount to the nearest whole penny. If the result of this calculation is different than the Paid Amount submitted on the encounter, edit MX41 will set and the encounter will reject.

EXAMPLES:

Date of Service	Billed Units	Rate per Mile	Billed Units x Rate	Rounded Paid Amt
1/1/2017	9.6	0.535	5.136	5.14
6/30/2016	9.6	0.54	5.184	5.18
9/15/2014	9.6	0.56	5.376	5.38

BUS Edit MX0000042	Origination Address cannot be the same as the Destination Address	Fatal Edit

Explanation: This edit will set when the encounter is for transportation miles (procedure codes “A0080”, “A0090”, “A0100”, “A0110”, “A0140”, and “T2004”) and origination address line 1 (2310E N301) is the same as the destination address line 1 (2310F NE01), and the origination zip code (2310E N403) is the same as the destination zip code (2010F N403).

BUS Edit MX0000043	Healthcare Provider Address cannot be the same as Client Address	Fatal Edit

Explanation: This edit will set when the healthcare provider's address (2310E N301) is the same as the client's address (2010BA N301), and the first five digits of healthcare provider's zip code (2310E N403) is the same as the first five digits of client's zip code (2010BA N403).

BUS Edit MX0000044	Date of Service is not before the Claim Date of Receipt and payment method is Advanced Funds or Credit Card.	Warning Edit

Explanation: The Date of Service (2300 DTP03) must occur on or prior to the Claim Date of Receipt (2300 NTE02). The transaction may not be submitted prior to the date of service. This edit will apply to scenarios where the payment method is Advanced Funds (AF) or Credit Card (CC).

BUS Edit MX0000045	Adjudication Date must be on or before TMHP Process Date	Fatal Edit

Explanation: The Adjudication Date (2330B/DTP03) must occur on or before the TMHP Process date. This edit will be set if the Adjudication Date submitted with a future date.

9. Appendices

9.1. Appendix A – 837P Example Transaction

The 837 transaction is designed to transmit one or more encounters for each billing provider. The hierarchy of the looping structure is billing provider, subscriber, claim level, and claim service line level. Submitters who sort encounters using this hierarchy will use the 837 more efficiently because information that applies to all lower levels in the hierarchy will not have to be repeated within the transaction.

Example TMHP 837P Transaction – ITP:

```
ISA*00*          *00*          *ZZ*999999999      *ZZ*617591011MTPT
*151104*0431*|*00501*000000103*1*P*:
GS*HC*999999999*617591011MTPP*20151104*0431*1674*X*005010X222A1
ST*837*1674*005010X222A1
BHT*0019*00*1674*20151104*0431*RP
NM1*41*2*MTO SUBMITTER NAME*****46*999999999
PER*IC*MTO CONTACT NAME*TE*8888888888
NM1*40*2*TMHP RECEIVER NAME*****46*617591011MTPP
HL*1**20*1
PRV*BI*PXC*347C00000X
NM1*85*1*BILLING ITP LASTNAME*FIRSTNAME
N3*100 NORTH MAIN ST
N4*AMARILLO*TX*791090000
REF*SY*777777777
REF*0B*666666666
HL*2*1*22*0
SBR*P*18*******11
NM1*IL*1*CLIENT LASTNAME*FIRSTNAME****MI*555555555
N3*100 EAST MAIN AVE
N4*AMARILLO*TX*791090000
DMG*D8*20150101*M
NM1*PR*2*TMHP PAYER NAME*****PI*617591011MTPP
N3*100 SOUTH MAIN BLVD
N4*AUSTIN*TX*787010000
REF*G2*TMX4444444
CLM*555555555*5.01***99:B:1*Y*A*Y*Y
DTP*435*D8*20151020
REF*G1*3333333
NTE*ADD*20151027188057057030000000DB19UUA56683A055657          A123456789
HI*ABK:Z753
NM1*77*2*HEALTHCARE PROVIDER NAME*****XX*2222222222
N3*100 WEST MAIN WAY
N4*DALLAS*TX*752350000
REF*G2*204F00000X
NM1*PW*2
N3*100 EAST MAIN AVE
N4*DALLAS*TX*752350000
NM1*45*2
N3*100 WEST MAIN WAY
N4*DALLAS*TX*752310000
SBR*S*18*******11
```

```
AMT*D*5.01
OI***N*P**Y
NM1*IL*1*CLIENT LASTNAME*FIRSTNAME****MI*555555555
N3*100 E MAIN AVE
N4*AMARILLO*TX*791090000
NM1*PR*2*MTO NAME*****PI*M3
N3*100 MAIN DRIVE
N4*RIDGELAND*MS*391572703
DTP*573*D8*20151030
REF*F8*00001234567
LX*1
SV1*HC:A0090*5.01*UN*8.95***1
DTP*472*D8*20151020
QTY*PT*2
NTE*ADD*P01
SE*54*1674
GE*1*1674
IEA*1*000000103
```

Example TMHP 837P Transaction – Demand Response:

```
ISA*00*          *00*          *ZZ*999999999      *ZZ*617591011MTPT
*151104*0431*|*00501*000000103*1*P*:
GS*HC*999999999*617591011MTPP*20151104*0431*1674*X*005010X222A1
ST*837*1674*005010X222A1
BHT*0019*00*1674*20151104*0431*RP
NM1*41*2*MTO SUBMITTER NAME*****46*999999999
PER*IC*MTO CONTACT NAME*TE*8888888888
NM1*40*2*TMHP RECEIVER NAME*****46*617591011MTPP
HL*1**20*1
PRV*BI*PXC*343800000X
NM1*85*2*BILLING PROVIDER ORG NAME*****XX*7777777777
N3*100 NORTH MAIN ST
N4*PLAINVIEW*TX*790720000
REF*EI*666666666
HL*2*1*22*0
SBR*P*18*******11
NM1*IL*1*CLIENT LASTNAME*FIRSTNAME****MI*555555555
N3*100 EAST MAIN AVE
N4*LUBBOCK*TX*794120000
DMG*D8*19650101*F
NM1*PR*2*TMHP PAYER NAME*****PI*617591011MTPP
N3*100 SOUTH MAIN BLVD
N4*AUSTIN*TX*787010000
CLM*4444444*30.00***99:B:1*Y*A*Y*Y
DTP*435*D8*20151002
REF*G1*5555555
NTE*ADD*20151010152152152020000000DB1D4GP24RX5B424122          A123456789
HI*ABK:Z753
NM1*82*1*PERFORMING PRV*DRIVER
REF*G2*TMX3333333
REF*0B*22222222
NM1*77*2*HEALTHCARE PROVIDER NAME*****XX*2222222222
N3*100 WEST MAIN WAY
N4*LUBBOCK*TX*794101160
```

```
REF*LU*111111101
REF*G2*207RA0201X
NM1*PW*2
N3*100 EAST MAIN AVE
N4*LUBBOCK*TX*794120000
NM1*45*2
N3*100 WEST MAIN WAY
N4*LUBBOCK*TX*794240000
SBR*S*18*******11
AMT*D*30.00
OI***N*P**Y
NM1*IL*1*CLIENT LASTNAME*FIRSTNAME****MI*666666666
N3*100 E MAIN AVE
N4*LUBBOCK*TX*794120000
NM1*PR*2*MTO PAYER NAME*****PI*M3
N3*100 MAIN DRIVE
N4*RIDGELAND*MS*391572703
DTP*573*D8*20150925
REF*F8*00001234567
LX*1
SV1*HC:A0100*30.00*UN*3.55***1
DTP*472*D8*20150910
NTE*ADD*P01
SE*55*1674
GE*1*1674
IEA*1*000000103
```

9.2. Appendix B – Texas Encounters Edit Descriptions

The table below is a quick reference guide of business edits.

Edit Number	Edit Description	Validation ANSI Loop / Segment	Edit Type: Warning (W) or Fatal (F)
Mx0000001	MTO Plan Code must be active on the date of service.	2330B NM108 - "PI" 2330B NM109 - Plan Code 2300 DTP01 = "435" - Date of Service Qualifier 2300 DTP03 - Date of Service	F
Mx0000002	Billing Provider submitted must be active in this plan on the date of service.	2300 DTP01 = "435" - Date of Service Qualifier 2300 DTP03 - Date of Service 2010AA NM109 - NPI 2010BB REF01 -"G2" API/MTI Qualifier 2010BB REF02 - API/MTI	F

Edit Number	Edit Description	Validation ANSI Loop / Segment	Edit Type: Warning (W) or Fatal (F)
		2330B NM108 - "PI" 2330B NM109 – Plan Code	
Mx0000003	Authorization Number is required.	2300 REF01 = "G1" - Authorization Number Qualifier 2300 REF02 - Authorization Number	F
Mx0000004	Procedure Code must be a valid value.	2400 SV101-2 - Procedure Code	F
Mx0000005	Claim Date of Receipt is required.	2300 NTE01 ="ADD" - Note segment Qualifier 2300 NTE02 bytes 1-8 - Claim Date of Receipt value	F
Mx0000006	Claim Date of Receipt must be in CCYYMMDD format.	2300 NTE01 = "ADD" - Note Segment Qualifier 2300 NTE02 bytes 1-8 - Claim Date of Receipt value	F
Mx0000007	Date of Service must be before the Claim Date of Receipt when encounter payment method is not Advanced Funds (AF) or Credit Card (CC)'.	2300 NTE01 = "ADD" - Note Segment Qualifier 2300 NTE02 bytes 1-8 - Claim Date of Receipt value 2300 DTP01 = "435" - Date of Service Qualifier 2300 DTP03 - Date of Service 2300 NTE01 = "ADD" - Note Segment Qualifier 2300 NTE02 - Note Field - payment method - bytes 26-27 invalid values: Advanced Funds = "AF" Credit Card = "CC"	F
Mx0000008	Special Needs code must be a valid value.	2300 NTE01 = "ADD" - Note Segment Qualifier 2300 NTE02 - Note Field - Special Needs special needs 1 - bytes 18-19 special needs 2 - bytes 20-21 special needs 3 - bytes 22-23 special needs 4 - bytes 24-25	F
Mx0000009	Payment Method must be a valid value.	2300 NTE01 = "ADD" - Note Segment Qualifier 2300 NTE02 - Note Field - payment method - bytes 26-27 valid values: Advanced Funds = "AF"	F

Edit Number	Edit Description	Validation ANSI Loop / Segment	Edit Type: Warning (W) or Fatal (F)
		Credit Card = "CC" Direct Bill = "DB"	
Mx0000010	Driver License Number is required and must match the driver license on file for submitted MTI.	2010AA REF02 - - Driver's License Number (ITPs) 2310B REF01 = "0B" - Driver's License Number Qualifier 2310B REF02 - Driver's License Number 2400 SV101-2 - Procedure code (ITPs - A0080, A0090; Non-ITPs - A0100)	W
Mx0000011	Driver License Number for submitted MTI must be active on date encounter is processed.	2010AA REF02 - Driver's License Number (ITPs) 2310B REF01 = "0B" - Driver's License Number Qualifier 2310B REF02 - Driver's License Number	W
Mx0000012	Performing Provider MTI submitted must be active in the plan on the date of service.	2310B REF01 = "G2" - MTI Qualifier 2310B REF02 - MTI 2300 DTP01 = "435" - Date of Service Qualifier 2300 DTP03 - Date of Service	F
Mx0000013	Healthcare Provider NPI/API is required.	2310C NM108 = “XX” - NPI 2310C REF01 = "LU"	F
Mx0000014	Healthcare Provider Taxonomy is required.	2310C REF01 - Taxonomy Code	F
Mx0000015	Date of Service (Travel Date) is required.	2300 DTP01 = "435" - Date of Service Qualifier 2300 DPT03 - Date of Service	F
Mx0000016	Date of Service (Travel Date) must be on or after 9/1/2014.	2300 DTP01 = "435" - Date of Service Qualifier 2300 DTP02 = "D8" 2300 DTP03 - Date of Service	F
Mx0000017	Origination Address is required when encounter is for travel, (airline, taxi, bus, or mileage reimbursement).	2310E NM102 = "2" 2310E N301, N401, N402, N403 – Origination Address 2400 SV102 - Procedure Codes: A0140 (Non-emergency transportation and air travel (private or commercial) intra or inter state) A0110 (Non-emergency transportation and bus, intra or inter state carrier) A0080 (Non-emergency transportation, per mile - vehicle	F

Edit Number	Edit Description	Validation ANSI Loop / Segment	Edit Type: Warning (W) or Fatal (F)
		provided by volunteer (individual or organization), with no vested interest) A0090 (Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest) T2004 (Non-emergency transport; commercial carrier, multi-pass) A0100 (Non-emergency transportation, taxi)	
Mx0000018	Destination Address is required when encounter is for travel, (airline, taxi, bus, or mileage reimbursement).	2310F NM102 = "2" 2310F N301, N401, N402, N403 – Destination Address 2400 SV102 - Procedure Codes: A0140 (Non-emergency transportation and air travel (private or commercial) intra or inter state) A0110 (Non-emergency transportation and bus, intra or inter state carrier) A0080 (Non-emergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest) A0090 (Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest) T2004 (Non-emergency transport; commercial carrier, multi-pass) A0100 (Non-emergency transportation, taxi)	F
Mx0000019	Number of One-Way Trips quantity is required and must be numeric.	2400 NTE01 = "ADD" - Note Segment Qualifier 2400 NTE02, bytes 2-3 - Number of One-Way Trips	F
Mx0000020	Subscriber less than 15 years old on date of service requires an attendant.	2010BA DMG02 - Subscriber DOB 2300 DTP03 - Date of Service 2400 QTY01 = “PT” 2400 QTY02 - Number of Attendants	F
Mx0000021	Subscriber is 15-17 years old on date of service requires an attendant when receiving non-family planning services.	2010BA DMG02 - Subscriber DOB 2300 DTP03 - Date of Service 2400 QTY01 = "PT" 2400 QTY02 - Number of Attendants	W

Edit Number	Edit Description	Validation ANSI Loop / Segment	Edit Type: Warning (W) or Fatal (F)
Mx0000022	Encounter Status Code is required and must be a valid value.	2400 NTE01 = "ADD" - Note Segment Qualifier 2400 NTE02, byte 1 - Encounter Status Code	F
Mx0000023	Paid Amount must be zero (0) when Encounter Status Code is 'D' (Denied).	2430/SVD02 – Detail Paid Amount 2400 NTE01 = "ADD" - Note Segment Qualifier 2400 NTE02, byte 1 - Encounter Status Code	F
Mx0000024	Claim Frequency Code must be '1' (Original), '7' (Adjustment), or '8' (Void).	2300 CLM05-3 - Claim Frequency Code	F
Mx0000025	A transaction must only have one detail segment.	loop 2400 - service line	F
Mx0000026	Adjudication Date is required.	2330B DTP01 = "573" - Date Qualifier 2330B DPT03 - Adjudication Date	F
Mx0000027	Adjudication Date must be on or after the Claim Receipt Date.	2300 NTE01 = "ADD" - Note Segment Qualifier 2300 NTE02, bytes 1-8 - Claim Receipt Date 2330B DTP01 = "573" - Date Qualifier 2330B DTP03 - Adjudication Date	W
Mx0000028	Provider's specialty must be valid for procedure code submitted.	2400 SV101-2 - Procedure code 2310B REF01 - "G2" - Performing Provider Qualifier 2310B REF02 - Performing Provider MTI 2010BB REF01 -"G2" API/MTI Qualifier 2010BB REF02 - API/MTI	F
Mx0000029	Billing Provider Taxonomy is required.	2000A PRV03 must be submitted	F
Mx0000030	Submitted Subscriber PCN must be on client eligibility file.	2010BA NM108 - "MI" - PCN Qualifier 2010BA NM109 - PCN	F
Mx0000031	Submitted Subscriber PCN must be eligible for MTP services according to client eligibility file.	2010BA NM108 - "MI" - PCN Qualifier 2010BA NM109 - PCN	W
Mx0000032	Submitted Subscriber Plan Code must match the plan code on the client eligibility file.	2330B NM108 - "PI" - Plan Code Qualifier 2330B NM109 - Plan Code	W
Mx0000033	An encounter transaction may only be submitted once.	2330B REF01 = "F8" - ICN Qualifier 2330B REF02 - ICN 2300 CLM05-3 = “1”	F
Mx0000034	Original ICN must be submitted for an adjusted or voided claim.	2300 REF01 = "F8" -Original ICN Qualifier	F

Edit Number	Edit Description	Validation ANSI Loop / Segment	Edit Type: Warning (W) or Fatal (F)
		2300 REF02 - Original ICN 2300 CLM05-3 = “7” or "8" 2330B NM108 - "PI" - Plan Code Qualifier 2330B NM109 - Plan Code	
Mx0000035	ICN must never have been previously adjusted or voided.	2300 REF01 = "F8" -Original ICN Qualifier 2300 REF02 - Original ICN 2300 CLM05-3 = “7” or "8" 2330B NM108 - "PI" - Plan Code Qualifier 2330B NM109 - Plan Code	F
Mx0000036	Submitter ID must match Sender ID.	Sender ID (ISA06) ≠ Submitter ID (1000A NM109)	F
Mx0000037	Billing provider taxonomy code must be a valid value.	2000A PRV03 is not one of the taxonomy codes valid for the MTP Program: 174200000X 177F00000X 343800000X 344800000X 347B00000X 347C00000X OR 2000A PRV03 is 347E00000X (aligns with MTP Provider Specialty TT – Broker)	F
Mx0000038	Lodging units cannot exceed 7 days per encounter	2400 SV104 - Billed Units 2400 SV101-2 - Procedure Code	F
Mx0000039	Meal units cannot exceed 7 meal days per recipient per encounter	2400 SV104 - Billed Units 2400 SV101-2 - Procedure Code 2400 QTY02 - Attendants	F
Mx0000040	Meal paid amount cannot exceed the MTP allowed amount.	2320 AMT02 - Header Paid Amount 2400 SV104 - Billed Units 2400 SV101-2 - Procedure Code	F
Mx0000041	Mileage reimbursement to ITPs must equal the MTP allowed amount	2320 AMT02 - Header Paid Amount 2400 SV101-2 - Procedure Code 2400 SV104 - Billed Units	F

Edit Number	Edit Description	Validation ANSI Loop / Segment	Edit Type: Warning (W) or Fatal (F)
Mx0000042	Origination Address cannot be the same as the Destination Address	Origination Address: 2310E N301 – Add Ln 1 2310E N403 – Zip Cd Destination Address: 2310F N301 – Add Ln 1 2310F N403 – Zip Cd 2400 SV101-2 – Procedure Codes	F
Mx0000043	Healthcare Provider Address cannot be the same as Client Address	Member Address: 2010BA N301 – Add Ln 1 2010BA N403 – Zip Cd Destination Address: 2310C N301 – Add Ln 1 2310C N403 – Zip Cd	F
Mx0000044	Date of Service is not before the Claim Date of Receipt and payment method is Advanced Funds or Credit Card.	2300 NTE01 = “ADD” – Note Segment Qualifier 2300 NTE02 bytes 1-8 – Claim Date of Receipt value 2300 DTP01 = “435” – Date of Service Qualifier 2300 DTP03 – Date of Service 2300 NTE01 = “ADD” – Note Segment Qualifier 2300 NTE02 - Note Field – payment method – bytes 26-27 valid values: Advanced Funds = “AF” Credit Card = “CC”	W
Mx0000045	Adjudication Date must be on or before TMHP Process Date	2330B DTP01 = "573" - Date Qualifier 2330B DTP03 - Adjudication Date	F

9.3. Appendix C – Change Log

Change Date	Section Reference	Description	Version Control Number
4/27/2017	8.3 & 9.2	• Updated sections for MX0000002, MX0000012, MX0000028 to reflect allowance for VOID submissions. • Added section for MX0000045. • Add examples of rounding to Edit MX0000041	12.0
2/24/17	8.3 & 9.2	• Updated sections for MX0000041 to reflect new ITP mileage reimbursement rate effective 1/1/17	11.0

Change Date	Section Reference	Description	Version Control Number
10/21/16	8.3 & 9.2	• Updated description and validation logic of MX0000007. • Added information for MX0000044	10.0
7/28/16	8.3 & 9.2	• Updated Edit Disposition of edits #s MX0000038, MX0000039, MX0000040, MX0000042 & MX0000043	9.0
4/13/16	7.1, 7.3, 7.4, & 7.5	• Updated sections 7.1, 7.3, & 7.4 to clarify use of Shared Services RefID . Updated section 7.5 to fix a typogrpahical error	8.0
2/10/16	8.3 & 9.2	• Updated Sections for edits related to Units and Attendants and addressess	7.0
11/20/2015	2, 3.2, 3.3, 3.4, 4.1, 4.2, 5.1, 5.3, 5.4, 6.1, 6.4, 7, 8.2, 9.1, 9.2	• Corrected grammar, punctuation, and capitalization and parentheses usage • Corrected expected values in ISA15. • Corrected Functional Group segment footer and clarified naming convention usage. • Modified data element formatting to allow for exceptions. • Updated response file descriptions and examples • Added scenarios for Advance Funds miles, meals and lodging; other minor corrections for clarity. • Removed examples and referred users to the Appendix for a full list of provider edits. • Clarified how TMHP identifies adjustments • Removed redundant reference to Claim Frequency Code • Removed redundant information; clarified the transactions involved. • Rewrote the section to remove redundant information and clarify process to avoid MTO confusion. • Removed redundant information; clarified the transactions involved. • New section specifying how to report Units and Attendants • Minor clarifications on existing edits MX0000007, MX0000010, MX0000011 • Modified explanation of edit MX0000034 to address MTO confusion • Added new edits MX0000038-MX0000043 in support of the new Units and Attendants requirements • Replaced existing X12 example with MTP data-specific examples • Modified edits MX0000017, MX0000018 to include additional validation data elements • Added validation elements for new edits MX0000038-MX0000043	6.0
04/07/2015	7.3 & 8.2	Added Edit Mx0000037	5.0
11/11/2014	7.3 & 3.4	Updated explanation for Edit MX0000007 Updated verbiage for TA1 Updated Segment from 2300 to 2330B for Edit MX0000033	4.0
08/26/2014	7.3 & 8.2	Updated explanation for Edit Mx0000029 Added Edit Mx0000036	3.0
07/23/2014	4.1, 8.1, & Appendix A	Updated with TMHP standardized PHI text and revised 837P example	2.0
6/25/2014		Initial Version	1.0

ANSI ASC X12N 837P
Health Care Encounter Professional

Managed Transportation Organization (MTO)

COMPANION GUIDE

February 10, 2016

Version 5.0

Table of Contents

1. Introduction

1.1 Preface

The TMHP 837P MTO Companion Guide is intended for trading partner use in conjunction with the ANSI ASC X12N Implementation Guide. The information in this Companion Guide describes TMHP specific data set requirements to be used for processing medical transportation encounter data. This companion guide supplements, but does not contradict any requirements in the X12N Implementation Guide which may be purchased at **http://www.wpc-edi.com**. TMHP does not use all the HIPAA data sets to process encounters.

1.2 Purpose

The 837 Professional Transaction is used to submit encounter data to the Texas Medical Transportation Program. The intent is to expedite the goal of achieving a totally electronic data interchange environment for encounter processing, and adjustments/corrections. MTO submitters must submit encounters in X12 837P format using the ASC X12 Electronic Transaction Standard published by the WPC. All encounter transactions must first satisfy the standard HIPAA rules for X12 837P; this Companion Guide provides information that reflects TMHP business rules that apply exclusively to medical transportation encounters under the MTO model.

The TMHP EDI Connectivity Guide that contains specific instructions regarding connectivity options can be found on the EDI page of the TMHP website at www.tmhp.com.

1.3 Contact Information

If there are questions or if support is required, please contact TMHP at MTOMailbox@tmhp.com.

1.4 Disclaimer

TMHP limits encounter files to 5,000 transactions per file (multiple ST-SE segments are allowed in a single batch GS-GE) and 75 megabytes (75 mb). If a file is submitted with more than 5,000 transactions or greater than 75 mb in file size, the entire file will be rejected and not processed by TMHP. However, multiple batches may be submitted to address this limitation.

1.5 Terms and Abbreviations

Acronym/Term	Acronym/Term Description or Definition
837P	837P (EDI file type) Professional Claim Transaction Type
ANSI	American National Standards Institute
API	Atypical Provider Identifier
ASC X12	Accredited Standards Committee is an organization chartered by ANSI, which develops and maintains healthcare EDI standards
Billing Provider	Provider or provider organization to which the MTO issues payment to for rendered services. Billing providers include, but are not limited to, Demand Response contractors/subcontractors, Individual Transportation Participants (self/other) and other entities.
CSHCN	Children with Special Health Care Needs
EDI	Electronic Data Interchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
ITP	Individual Transportation Participant
MTI	Managed Transportation Identifier, assigned by MTOs to billing and performing providers.
MTO	Managed Transportation Organization
NPI	National Provider Identifier
Performing Provider	Person (i.e. Demand Response driver) or organization, which rendered the services. Performing providers include, but are not limited to, Demand Response subcontractors' drivers, Individual Transportation Participants (self/other) and other entities.
TICP	Texas Interoperable Communications Package
TMHP	Texas Medicaid & Healthcare Partnership
WPC	Washington Publishing Company

2. 837P Health Care Encounter – Professional

This section is used to describe the *required* data sets for medical transportation encounter processing by TMHP. The 837P format is used for submission of electronic encounters for MTOs. This is the file that is sent to TMHP for processing.

The TMHP 837P MTO Encounters Submission Guidelines provide additional instructions and guidance on the submission of encounters. Please refer to the MTO Encounters Submission Guidelines, which is located in the MTPLAYOUT folder on TXMedCentral.

837P Transaction TMHP Specific Data

The table below outlines TMHP specific data set requirements for MTOs.

Loop ID	Element ID	Data Value	Description
Control Segments			
Interchange Control Header			
	ISA05	"ZZ"	This mutually defined value is used to submit this file format to TMHP.
	ISA06	"T" or "P"	TMHP will assign submitter a test and production Submitter ID.
	ISA07	"ZZ"	This mutually defined value is used to submit this file format to TMHP.
	ISA08	Production = 617591011MTPP Testing = 617591011MTPT	This is the TMHP Receiver ID used by EDI for recognition. The last character of the ID must change to correspond with the environment to which the transaction is submitted (i.e., "P" for Production environment, and "T" for Regression test environment.
	ISA11	| (pipe – not alpha character)	TMHP requests that all submitters send a | (pipe – not alpha) in the ISA11 field as the Repetition Separator. This is a required field in the X12, and also must be different than the data element separator, component element separator, and the segment terminator but TMHP does not support the processing of repeated occurrences of a simple data element or a composite data structure.
	ISA15	"P"	Populate with "P" regardless of the value submitted in ISA08
Functional Group			
	GS08	005010X222A1	TMHP will support the approved addenda for 837P.
Beginning of Hierarchical Transaction			
	BHT02	"00"	TMHP will process all 837 files as original.
	BHT03	1-30 alphanumeric	TMHP sends any inbound BHT03 value back on the 277CA response file. The BHT03 is the number assigned by the submitter (submitter's batch id or batch control number) used to identify the transaction within their system.
	BHT06	"RP"	TMHP will process all 837 transactions as encounters.
Billing Provider Information (Loop Required-TMHP)			
2000A	PRV02	"PXC"	Required qualifier value.
2000A	PRV03	10 alphanumeric	PRV03 must contain the provider's assigned taxonomy. See Appendix A.
Billing Provider Information (Loop Required-HIPAA)			
2010AA	NM108	"XX"	If the NPI is submitted, the value of NM108 must contain XX. **Note:** The Atypical Provider Identifier (API) or the Managed Transportation Identifier (MTI) will be reported in Loop 2010BB.
2010AA	NM109	10 alphanumeric	**Provider NPI**: NM109 must contain the provider's assigned NPI for providers enrolled with TMHP.
2010AA	REF01	"EI", "SY"	The value of REF01 must contain EI (EIN) or SY (SSN).
2010AA	REF02	9 alphanumeric	REF02 must contain the EIN or the SSN.
2010AA	REF01	"0B"	**Driver's License:** Only for ITP Providers (Specialty Code "T4"). The value of REF01 must contain 0B (State License Number). If the billing provider is not an ITP, this segment is not required.
2010AA	REF02	1-20 alphanumeric	Populate with the driver's license number.

Loop ID	Element ID	Data Value	Description
Subscriber Name (Client Details)			
2010BA	NM108	"MI"	TMHP requests that the submitter enter "MI" for the Client ID.
2010BA	NM109	9 alphanumeric	**Subscriber's Patient Control Number:** Populate with client's 9-digit Medicaid number, 9-digit CSHCN number or TICP number.
Payer Name			
2010BB	NM108	"PI"	TMHP is requesting that the submitter populate this segment with "PI" for the Payer Identification.
2010BB	NM109	617591011MTPP 617591011MTPT	This is TMHP's EDI Transaction Payer ID.
2010BB	REF01	"G2"	**Billing Provider MTI**: The value of REF01 must contain G2 (Provider Commercial Number) when the MTI (Managed Transportation Identifier) is sent in REF02.
2010BB	REF02	10 alphanumeric	**Billing Provider MTI:** REF02 must contain the MTI (Managed Transportation Identifier) where the MTI is T + Plan Code + seven digits.
Claim Information			
2300	CLM05-1	"99"	TMHP requests the submitter populate this element (Place of Service) with "99" – Other Place of Service.
2300	CLM05-3	"1" (Original) "7" (Adjustment) "8" (Void)	**Claim Frequency Code**: TMHP will read this value as an original *encounter*. TMHP will read this value as an (adjustment). TMHP will read this value as a *voided encounter*.
Original Reference Number			
2300	REF01	"F8"	TMHP requests that the submitter populate this element with "F8" when submitting an adjustment or void.
2300	REF02	1-30 alphanumeric	TMHP requests the submitters to populate this element with the ICN of the encounter being adjusted or voided. See Sections 5 and 6 of the MTO Encounters Submission Guidelines document, located in the /MTPCOMMON/MTPLAYOUT folder in TXMedCentral for details on submitting adjusted or voided transactions.
Claim Note Information			
2300	NTE01	"ADD"	TMHP request the submitter populate this element with "ADD" to refer to Additional Information.
2300	NTE02	1-64 alphanumeric	TMHP will only read the first 64 characters of the 80 available. TMHP requests that submitters send data in the NTE segment associated with the service line on the claim. For the optional data elements, please zero fill those that do not have actual data. The submitter should follow the below segment layout: Positions 1 -8 Date of Receipt (YYYYMMDD) – Required

<table>
<tr><th>Loop ID</th><th>Element ID</th><th>Data Value</th><th>Description</th></tr>
<tr><td></td><td></td><td></td><td>
County Codes:
Positions 9 - 11 Subscriber's County Code – Optional
Positions 12 - 14 Origination Address County Code - Optional
Positions 15 -17 Destination Address County Code – Optional

Special Needs:
Positions 18 - 19 Special Needs 1 - Required
Positions 20 - 21 Special Needs 2 - Required
Positions 22 - 23 Special Needs 3 - Required
Positions 24 - 25 Special Needs 4 – Required

<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>00</td><td>No Special Need</td></tr>
<tr><td>01</td><td>Blind</td></tr>
<tr><td>02</td><td>Cane</td></tr>
<tr><td>03</td><td>Car Seat Required</td></tr>
<tr><td>04</td><td>Crutches</td></tr>
<tr><td>05</td><td>Deaf</td></tr>
<tr><td>06</td><td>Electric Wheel Chair</td></tr>
<tr><td>07</td><td>Legally Blind</td></tr>
<tr><td>08</td><td>Limited English</td></tr>
<tr><td>09</td><td>Mentally Impaired</td></tr>
<tr><td>10</td><td>Mute</td></tr>
<tr><td>11</td><td>Scooter</td></tr>
<tr><td>12</td><td>Service Animal</td></tr>
<tr><td>13</td><td>Vehicle with Lift</td></tr>
<tr><td>14</td><td>Vehicle with Low Access</td></tr>
<tr><td>15</td><td>Vehicle with Ramp</td></tr>
<tr><td>16</td><td>Visually Impaired</td></tr>
<tr><td>17</td><td>Walker</td></tr>
<tr><td>18</td><td>Front Seat</td></tr>
<tr><td>19</td><td>Epileptic</td></tr>
<tr><td>20</td><td>Wheel Chair</td></tr>
<tr><td>21</td><td>Stretcher Service</td></tr>
</table>

Payment Method:
Positions 26 – 27 Payment Method - Required

MTOs must provide the method for reimbursement of services.

<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>AF</td><td>Advanced Funds</td></tr>
<tr><td>CC</td><td>Credit Card</td></tr>
<tr><td>DB</td><td>Direct Bill</td></tr>
</table>

Providers with Specialty Codes (TR, TZ, T4, TS, or TD) need to provide the VIN:
</td></tr>
</table>

Loop ID	Element ID	Data Value	Description
			Vehicle Identification Number (VIN): Positions 28 – 44 Vehicle Identification Number **Shared Services Ref ID:** *(MTOs will be notified on the effective date)* Positions 45 - 64 Shared Services ID - Situational Required when MTP services rendered in a single encounter are shared by multiple members. MTOs must submit an encounter for each member, and provide a reference number to link all encounters associated with the shared service. If the Shared Services ID is more than 20 characters long, submit the last 20 characters of the value. If the ID is less than 20 characters, submit the value right-justified, space-filled. If the ID is not required, do not submit.
Health Care Diagnosis Code			
2300	HI01-1	"ABK" or "BK"	Populate this element with "ABK" for encounters submitted on or after 10/1/2015. Populate this element with "BK" for encounters submitted before 10/1/2015.
2300	HI01-2	"Z753" or "7999"	When "ABK" is submitted in HI01-1 then the value of HI01-2 is "Z753". When "BK" is submitted in HI01-1 then the value of HI01-2 is "7999".
Date of Service (Travel Date) Information			
2300	DTP01	"435"	The value of DTP01 must contain "435" (Admission).
2300	DTP02	"D8"	The value of DTP02 must contain "D8" (Date Expressed in Format CCYYMMDD).
2300	DTP03	8 alphanumeric	Populate with the Date of Service (travel date) in CCYYMMDD format.
Authorization Number			
2300	REF01	"G1"	The value of REF01 must contain "G1" (Prior Authorization Number)
2300	REF02	1-50 alphanumeric	REF02 must contain the authorization number.
Performing Provider (Driver) Information			
2310B	REF01	"0B"	**Driver's License Number**: Only for Demand Response drivers (Specialty Code TZ" and "TD"): The value of REF01 must contain "0B" (State License Number).
2310B	REF02	1-20 alphanumeric	Populate with the driver's license number.
2310B	REF01	"G2"	**MTI**: The value of REF01 must contain "G2" (Provider Commercial Number)
2310B	REF02	10 alphanumeric	Populate with the driver's MTI number.
Healthcare Provider Information			
2310C	NM108	"XX"	The value of NM108 must contain "XX" (NPI).
2310C	NM109	10 alphanumeric	**Healthcare Provider NPI**: NM109 must contain the provider's assigned NPI.
2310C	REF01	"0B"	The value of REF01 must contain "0B" (State License Number) when the Healthcare Provider's Tax ID or SSN is sent.

Loop ID	Element ID	Data Value	Description
2310C	REF02	1-30 alphanumeric	REF02 must contain the Tax ID or SSN (up to 30 alphanumeric).
2310C	REF01	"G2"	The value of REF01 must contain "G2" (Provider Commercial Number) when the Healthcare Provider taxonomy is sent.
2310C	REF02	10 alphanumeric	REF02 must contain the Taxonomy (10 alphanumeric).
2310C	REF01	"LU"	The value of REF01 must contain LU (Location Number) when the Healthcare Provider TPI and suffix (API) is sent.
2310C	REF02	10 alphanumeric	REF02 must contain the TPI and suffix (API) (10 alphanumeric).
Origination Address (Appointment Details)			
2310E	N301	1-55 alphanumeric	Populate the Origination Address information.
2310E	N401	2-30 alphanumeric	Populate the Origination Address City.
2310E	N402	2 alphanumeric	Populate the Origination Address State.
2310E	N403	9 alphanumeric	Populate the Origination Address 9-digit Zip Code.
Destination Address (Appointment Details			
2310F	N301	1-55 alphanumeric	Populate the Destination Address information.
2310F	N401	2-30 alphanumeric	Populate the Destination Address City.
2310F	N402	2 alphanumeric	Populate the Destination Address State.
2310F	N403	9 alphanumeric	Populate the Destination Address 9-digit Zip Code.
Other Subscriber Information (COB Payer Paid Amount)			
2320	AMT01	"D"	TMHP requests the submitter populate this element with "D" for the Coordination of Benefits (COB) Payer Paid Amount when the encounter is Paid. Do not submit the segment if the encounter status is Denied.
2320	AMT02		TMHP requests the submitter to populate this element with the total amount of money that the plan has paid on this transaction. It is acceptable to show "0" amount paid. *New requirements are effective February 26, 2016.* *See Section 7 of the MTO Encounters Submission Guidelines document, located in the /MTPCOMMON/MTPLAYOUT folder in TXMedCentral for requirements for reporting paid amounts.*
Other Payer Name			
2330B	NM108	"PI"	TMHP requests the submitter populate this element with "PI" for the Payer Identification.
2330B	NM109	2 alphanumeric	**MTO Plan Code:** TMHP requests the submitter populate this element with the MTO Plan Code.
2330B	REF01	"F8"	TMHP requests the submitter populate this element with "F8" for the Original Reference Number.
2330B	REF02	1-50 alphanumeric	**Paying ICN:** TMHP requests the submitter populates this element with the ICN the plan applied to this transaction. Positions 1,2,3,4 are reserved for the sequence number. All four positions must be populated (0001) as opposed to (1). If the plan does not use the sequence number in its processing, enter four zeroes (0000).
Service Line			
2400	SV101-1	"HC"	TMHP request the submitter populate this segment with "HC" to refer to Health Care Financing Administration Common

Loop ID	Element ID	Data Value	Description
			Procedural Coding System (HCPCS) Codes.
2400	SV101-2		**Procedure Code:** TMHP requests the submitter to populate with the procedure code. See Appendix A.
2400	SV104		THMP requests the submitter to populate this element with the billed units for meals, lodging, airline travel, intercity bus and mass transit, and transportation miles provided by demand response drivers and ITPs. *New requirements are effective February 26, 2016.* *See Section 7 of the MTO Encounters Submission Guidelines document, located in the /MTPCOMMON/MTPLAYOUT folder in TXMedCentral for requirements for reporting billed units.*
2400	DTP01	"472"	The value of DTP01 must contain "472" (Service).
2400	DTP02	"D8" "RD8"	**Healthcare Appointment Date:** The value of DTP02 must contain either: "D8" if Healthcare Appointment From Date only is provided, or "RD8" if Healthcare Appointment From and To Date are both provided. "RD8" is required only when the "To and From" dates are different.
2400	DTP03	1-35 alphanumeric	Populate with the Appointment Date , and if applicable, Healthcare Appointment To Date. If DTP02 is "D8", as CCYYMMDD, or If DPT02 is "RD8", as CCYYMMDD-CCYYMMDD
2400	QTY01	"PT"	The value of QTY01 must = "PT"
2400	QTY02		**Number of Attendants:** TMHP requests the submitter to populate this element only when an attendant is required. It should be populated with the number of travelers (attendants plus client) *New requirements are effective February 26, 2016.* *See Section 7 of the MTO Encounters Submission Guidelines document, located in the /MTPCOMMON/MTPLAYOUT folder in TXMedCentral for requirements for reporting Attendants.* Note: When the encounter is client only (no attendant), this element should not be submitted.
Line Note (Trip Details and Encounter Status Code)			
2400	NTE01	"ADD"	TMHP request the submitter populate this element with "ADD" to refer to Additional Information.
2400	NTE02	1-3 alphanumeric	TMHP will only read the first three 3) characters of the 80 available. TMHP requests that submitters send data in the NTE segment

<table>
<tr><th>Loop ID</th><th>Element ID</th><th>Data Value</th><th>Description</th></tr>
<tr><td></td><td></td><td></td><td>associated with the service line on the claim. The submitter should follow the segment layout below:

Encounter Status:
Position 1 Encounter Status Code – Required
<table><tr><th>Code</th><th>Description</th></tr><tr><td>“P”</td><td>Paid</td></tr><tr><td>“D”</td><td>Denied</td></tr></table>
Number of One-Way Trips
Positions 2 - 3 Number of one-way trips – Required

Number of one-way trips must be populated (01), as opposed to (1).
Number of one-way trips must be populated (01) as opposed to (1).</td></tr>
</table>

3. Appendices:

3.1 Appendix A: MTP Procedure Code Values

Provider/Participant	Enrollment (TMHP or MTO)	Provider Specialty	Provider Specialty Description	Provider Type	Taxonomy	Procedure Code	Billing Provider	Performing Provider*
Managed Transportation Organization Demand Response Waiver	TMHP	TR	Demand Response MTO Waiver	MT	343800000X - Secured Medical Transport (VAN), Transportation Services	A0100 - Non-emergency transportation, taxi	Yes	No
Managed Transportation Organization Demand Response Waiver Driver	MTO	TZ	Demand Response MTO Driver Waiver	MT	343800000X - Secured Medical Transport (VAN), Transportation Services	A0100 - Non-emergency transportation, taxi	No	Yes
ITP Self	MTO	T4	Individual Transportation Participant (ITP)	MT	347C00000X - Private Vehicle, Transportation Services	A0090 - Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest.	Yes	Yes
ITP Other	MTO	T4	Individual Transportation Participant (ITP)	MT	347C00000X - Private Vehicle, Transportation Services	A0080 - Non-emergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest	Yes	Yes
Demand Response Subcontractor	TMHP	TS	Demand Response Subcontractor	MT	343800000X - Secured Medical Transport (VAN), Transportation Services	A0100 - Non-emergency transportation, taxi	Yes	No

Provider/Participant	Enrollment (TMHP or MTO)	Provider Specialty	Provider Specialty Description	Provider Type	Taxonomy	Procedure Code	Billing Provider	Performing Provider*
Demand Response Subcontractor Driver	MTO	TD	Demand Response Subcontractor Driver	MT	343800000X - Secured Medical Transport (VAN), Transportation Services	A0100 - Non-emergency transportation, taxi	No	Yes
Meals Provider/Contractor	MTO	T8	Meals	MT	174200000X - Meals, Other Service Providers	A0190 - Non-emergency transportation: ancillary: meals-recipient	Yes	Yes
Lodging Provider	MTO	T6	Lodging	MT	177F00000X - Lodging, Other Service Providers	A0180 - Non-emergency transportation: ancillary: lodging-recipient	Yes	Yes
Bus	MTO	T3	Intercity Bus (Greyhound)	MT	347B00000X - Bus, Transportation Services	A0110 - Non-emergency transportation and bus, intra or interstate carrier	Yes	Yes
Mass Transit	MTO	T7	Mass Transit	MT	347B00000X - Bus, Transportation Services	T2004 - Non-emergency transport; commercial carrier, multi-pass	Yes	Yes
Airline Travel	MTO	T2	Airline Travel	MT	344800000X - Air Carrier, Transportation Services	A0140 - Non-emergency transportation and air travel (private or commercial) intra or inter state	Yes	Yes

***When Performing Provider is same as Billing Provider, only submit Billing Provider.**
Important: Procedure codes billed are considered to be the type of service (TOS) rendered by the MTO. Therefore, TOS is not required to be included in the claim /encounter.

3.2 Appendix B:837P Example Transaction

The 837P transaction is designed to transmit one or more transactions for each billing provider. The hierarchy of the looping structure is billing provider, subscriber, claim level, and claim service line level. Files submitted using this hierarchy are more efficient because information that applies to all lower levels in the hierarchy will not have to be repeated within the transaction. The example included below combines elements from both the Implementation Guide and MTO Companion Guide.

TMHP Note:
As an assumption for these file formats, if the Subscriber is the same individual as the Patient, then the Patient Loop is not to be populated per HIPAA compliance. Information sent in the 2000C loop will be ignored by TMHP.

In the following example, carriage return line feeds are inserted in place of ~ character for improved readability purposes.

Example TMHP 837P Transaction – ITP:

ISA*00* *00* *ZZ*999999999 *ZZ*617591011MTPT *151104*0431*|*00501*000000103*1*P*:
GS*HC*999999999*617591011MTPP*20151104*0431*1674*X*005010X222A1
ST*837*1674*005010X222A1
BHT*0019*00*1674*20151104*0431*RP
NM1*41*2*MTO SUBMITTER NAME*****46*999999999
PER*IC*MTO CONTACT NAME*TE*8888888888
NM1*40*2*TMHP RECEIVER NAME*****46*617591011MTPP
HL*1**20*1
PRV*BI*PXC*347C00000X
NM1*85*1*BILLING ITP LASTNAME*FIRSTNAME
N3*100 NORTH MAIN ST
N4*AMARILLO*TX*791090000
REF*SY*777777777
REF*0B*666666666
HL*2*1*22*0
SBR*P*18*******11
NM1*IL*1*MEMBER LASTNAME*MEMBER FIRSTNAME****MI*555555555
N3*100 EAST MAIN AVE
N4*AMARILLO*TX*791090000
DMG*D8*20150101*M
NM1*PR*2*TMHP PAYER NAME*****PI*617591011MTPP
N3*100 SOUTH MAIN BLVD
N4*AUSTIN*TX*787010000
REF*G2*TMX4444444
CLM*555555555*5.01***99:B:1*Y*A*Y*Y
DTP*435*D8*20151020
REF*G1*3333333
NTE*ADD*20151027188057057030000000DB19UUA56683A055657 A123456789
HI*ABK:Z753
NM1*77*2*HEALTHCARE PROVIDER NAME*****XX*2222222222
N3*100 WEST MAIN WAY
N4*DALLAS*TX*752350000
REF*G2*204F00000X
NM1*PW*2
N3*100 EAST MAIN AVE
N4*DALLAS*TX*752350000
NM1*45*2

N3*100 WEST MAIN WAY
N4*DALLAS*TX*752310000
SBR*S*18*******11
AMT*D*5.01
OI***N*P**Y
NM1*IL*1*MEMBER LASTNAME*MEMBER FIRSTNAME****MI*555555555
N3*100 E MAIN AVE
N4*AMARILLO*TX*791090000
NM1*PR*2*MTO NAME*****PI*M3
N3*100 MAIN DRIVE
N4*RIDGELAND*MS*391572703
DTP*573*D8*20151030
REF*F8*00001234567
LX*1
SV1*HC:A0090*5.01*UN*8.95***1
DTP*472*D8*20151020
QTY*PT*2
NTE*ADD*P01
SE*54*1674
GE*1*1674
IEA*1*000000103

Example Accenture 837P Transaction – Demand Response:

ISA*00* *00* *ZZ*999999999 *ZZ*617591011MTPT *151104*0431*|*00501*000000103*1*P*:
GS*HC*999999999*617591011MTPP*20151104*0431*1674*X*005010X222A1
ST*837*1674*005010X222A1
BHT*0019*00*1674*20151104*0431*RP
NM1*41*2*MTO SUBMITTER NAME*****46*999999999
PER*IC*MTO CONTACT NAME*TE*8888888888
NM1*40*2*TMHP RECEIVER NAME*****46*617591011MTPP
HL*1**20*1
PRV*BI*PXC*343800000X
NM1*85*2*BILLING PROVIDER ORG NAME*****XX*7777777777
N3*100 NORTH MAIN ST
N4*PLAINVIEW*TX*790720000
REF*EI*666666666
HL*2*1*22*0
SBR*P*18*******11
NM1*IL*1*MEMBER LASTNAME*FIRSTNAME****MI*555555555
N3*100 EAST MAIN AVE
N4*LUBBOCK*TX*794120000
DMG*D8*19650101*F
NM1*PR*2*TMHP PAYER NAME*****PI*617591011MTPP
N3*100 SOUTH MAIN BLVD
N4*AUSTIN*TX*787010000
CLM*4444444*30.00***99:B:1*Y*A*Y*Y
DTP*435*D8*20151002
REF*G1*5555555
NTE*ADD*20151010152152152020000000DB1D4GP24RX5B424122 A123456789
HI*ABK:Z753
NM1*82*1*PERFORMING PRV*DRIVER
REF*G2*TMX3333333
REF*0B*22222222
NM1*77*2*HEALTHCARE PROVIDER NAME*****XX*2222222222
N3*100 WEST MAIN WAY
N4*LUBBOCK*TX*794101160
REF*LU*111111101

REF*G2*207RA0201X
NM1*PW*2
N3*100 EAST MAIN AVE
N4*LUBBOCK*TX*794120000
NM1*45*2
N3*100 WEST MAIN WAY
N4*LUBBOCK*TX*794240000
SBR*S*18*******11
AMT*D*30.00
OI***N*P**Y
NM1*IL*1*MEMBER LASTNAME*FIRSTNAME****MI*666666666
N3*100 E MAIN AVE
N4*LUBBOCK*TX*794120000
NM1*PR*2*MTO PAYER NAME*****PI*M3
N3*100 MAIN DRIVE
N4*RIDGELAND*MS*391572703
DTP*573*D8*20150925
REF*F8*00001234567
LX*1
SV1*HC:A0100*30.00*UN*3.55***1
DTP*472*D8*20150910
NTE*ADD*P01
SE*55*1674
GE*1*1674
IEA*1*000000103

3.3 Appendix *C*:Summary of Version Changes

The following is a log of changes made since the original version of the document was published.

	Change	Date
1.	Added Vehicle Identification Number (VIN) to 2300 NTE02, Updated Section 3.1 Appendix A with new Provider Specialty codes	06/25/2014
2.	Updated Section 3.2 Appendix B, with TMHP standard PHI text and revised example. Removed reference to ICD-10 diagnosis codes from Health Care Diagnosis Code.	07/23/2014
3.	Added reference to ICD-10 diagnosis code to Health Care Diagnosis Code and clarified language in description of 2300 REF01	10/15/2015
4.	• ISA15 - Clarified expected value • 2300/NTE02 at positions 45-64 - Added Shared Services data element associated with the new Units and Attendants solution • 2300/REF02 - Clarified prior transaction ID value expected for voids and adjustment submissions • 2300/HI01 - Added reference to ICD-10 diagnosis code to Health Care Diagnosis Code and clarified language in description. • 2320/AMT01 - Added expected qualifier for MTO Paid Amount. • 2400/SV104 - Clarified expected billed units. • Updated examples to be consistent with the MTO solution. • Rephrased sentence tructure to improve clarity without changing the content. • Addressed grammar and punctuation errors.	11/20/2015
5.	• Updated Effective Date for the requirements related to Units and Attendants. Applied minor formatting changes	2/10/2016

MT88 Managed Transportation Organization (MTO)

COMPANION GUIDE

January 27, 2017

Version 3.0

Table of Contents

1. Introduction

1.1 Preface

The MT88 MTO Companion Guide is intended for the MTO and describes TMHP specific data set requirements to be used for processing MTO provider data.

1.2 Purpose

The MT88 MTO Network File provides a listing of the active Medical Transportation (MTP) Providers and Participants contracting with each Managed Transportation Organization (MTO). A separate file will be delivered by the MTO to the Texas Medicaid & Healthcare Partnership (TMHP) for each region. The Texas Medical Transportation System (TMTS) will validate the Driver's License (DL) submitted on the file. TMTS will add an indicator based on the result of the DL validation on the file and deliver it to TMHP and the MTO. The TMHP Electronic Data Interchange (EDI) system will validate and load the provider/participant records into the Operational Data Store (ODS) for extraction to the Vision21 (V21) Data and MTP Encounter Warehouse. The information loaded into the ODS will be used by TMHP to validate encounters submitted by the MTOs. The file is processed sequentially in the order the records are received in the file.

1.3 Contact Information

If there are questions or if support is required, please contact TMHP at MTOMailbox@tmhp.com.

1.4 Terms and Abbreviations

Acronym/Term	Acronym/Term Description or Definition
API	Atypical Provider Identifier
EDI	Electronic Data Interchange
ITP	Individual Transportation Participant
MTI	Managed Transportation Identifier, assigned by MTOs to billing and performing providers.
MTO	Managed Transportation Organization
NPI	National Provider Identifier
ODS	Operational Data Store
TMHP	Texas Medicaid & Healthcare Partnership
TMTS	Texas Medical Transportation System

2. MT88 MTO Network File Layout

Submission Frequency: A full replacement of MT88 should be submitted at least twice a month (Recommended Submission: 1st and 16th day of the month)

Sender: MTO via the TXMEDCENTRAL to the MTO *LIB folder

Receivers: TMTS and TMHP

File Naming Convention: MT88rrjjj.txt

- rr = Region Code
- jjj = Julian Date

DL Validation Process: HHSC-IT runs DL validation of MT88 records through TMTS daily at 7pm CST

Layout Legend:
Location – byte position of beginning and end of data field
Description – data element stored in field
Type – data classification (C – character; N – number; AN – alpha-numeric)
Size – length of data field
Values – accepted data values
Comments – additional details.

Location	Data Element	Description	Type	Size	Values	Comments
1 - 2	MTO Plan Code	MTO Plan Code	AN	2	M1, M2, M3, M4, M5, M6, M7, M8, M9, MB, MC, MD, ME	A two-character value indicating a particular MTO.

Location	Data Element	Description	Type	Size	Values	Comments
3 - 12	Provider ID	NPI or API or MTO ID (MTI)	AN	10		NPI is a nationally-assigned identifier for healthcare providers beginning with a number. API is a TMHP-assigned identifier for non-medical providers beginning with an 'A.' MTI will be a MTO-assigned identifier for any providers/participants not required to enroll with TMHP and will be formatted as 'T' + Plan Code + 7 unique digits.
13 - 21	TPI	Texas Provider Identifier (TPI)	AN	9		Base and suffix identifier assigned during enrollment at TMHP. Only required for NPI or API.
22 - 31	Taxonomy Code	Taxonomy Code	AN	10	347E00000X - Transportation Broker, Transportation Services 343800000X - Secured Medical Transport (VAN), Transportation Services 347C00000X - Private Vehicle, Transportation Services 174200000X - Meals, Other Service Providers 177F00000X - Lodging, Other Service Providers 347B00000X - Bus, Transportation Services 344800000X - Air Carrier, Transportation Services	A national code for classifying a set of procedures a person or entity is permitted to perform.
32 - 81	Last Name/Org Name	Last Name or Organization Name	AN	50		The surname of an individual or the company name of an organization
82 - 131	First Name	First Name	AN	50		The given name, or forename, of an individual
132 - 132	Middle Initial	Middle Initial	AN	1		The first letter of the provider/participant middle name

Location	Data Element	Description	Type	Size	Values	Comments
133 - 133	Gender	Gender Code	AN	1	M - Male F - Female U - Unknown	Gender of the provider/participant Organizations provide “U”
134 - 173	Address Line 1	Address Line 1	AN	40		Physical/Business address information for determining a building’s location (i.e. House number and street name)
174 - 213	Address Line 2	Address Line 2	AN	40		Additional address information for identifying a portion of a building (i.e. Apartment number or Suite)
214 - 238	City	City	AN	25		City name of address
239 - 240	State	State	AN	2		State name of address
241 - 249	ZIP	Zip+4	N	9		United States Postal Service assigned location code, including 4-digit sector/segment code. (ex. 78731-5904 is 787315904) If 5-character ZIP is provided, include 4 trailing 0’s
250 - 252	County Code	County Code	AN	3	See County Code list at end of document	The Texas Department of Health (TDH) county code of the location defined by the address fields
253 - 253	Border State Indicator	Border State Indicator	AN	1	0 - no 1 - yes	A code indicating that the location is outside of state boundaries for the location being captured. (The provider location is out of state, but for payment purposes the provider is treated as an in-state provider.)
254 - 263	Phone Number	Phone Number	AN	10		The primary phone number of the provider/participant must be in ‘##########’ format
264 - 273	Fax Number	Fax Number	AN	10		The fax number of the provider/participant must be in ‘##########’ format
274 - 333	E-mail	E-mail Address	AN	60		Primary e-mail address of the provider/participant
334 - 335	Provider Type	Provider Type	AN	2	MT - Medical Transportation Provider	The Provider Type code that would appear for an MTP provider or participant

Location	Data Element	Description	Type	Size	Values	Comments
336 - 337	Specialty Code	Specialty Code	AN	2	TT - Broker TR - Demand Response MTO Waiver TZ - Demand Response MTO Driver Waiver TS - Demand Response Subcontractor TD - Demand Response Subcontractor Driver T2 - Airline Travel T3 - Intercity Bus (Greyhound) T4 - Individual Transportation Participant (ITP) T6 - Lodging T7 - Mass Transit T8 - Meals	A two-character value indicating the scope of services a provider/participant may provide
338 - 346	TIN	Tax ID Number (TIN)	AN	9		The taxpayer's identification number as it would appear on a W2. This would be the IRS-assigned ID or Social Security Administration SSN
347 - 348	DL State	DL State	AN	2		The two-character abbreviation for the State that issued the MTP's driver's license
349 - 368	DL #	DL #	AN	20		The identification number of a driver's license
369 - 376	Date of Birth	Date of Birth	AN	8	ccyymmdd	Birthdate of provider/participant Required for MTI with specialty code of TZ, TD or T4
377 - 384	Date of Death	Date of Death	AN	8	ccyymmdd	Date from death certificate for provider/participant Required for MTI with specialty code of TZ, TD or T4 This date is expected to be '39991231' unless the provider/participant is deceased.
385 - 392	Effective Date	Effective Date	AN	8	ccyymmdd	The first date an MTP provider/participant is contracted with an MTO
393 - 400	Terminate Date	Terminate Date	AN	8	ccyymmdd	The date an MTP provider/participant is no longer contracted with an MTO. This date is expected to be '39991231' until the provider/participant is terminated from the MTO plan

Location	Data Element	Description	Type	Size	Values	Comments
401 - 401	DL Validity Indicator	DL Validity Indicator	AN	1	Y - Valid N - Invalid O - Out of State X - Not Provided (fails validation)	A field populated by TMTS, not populated by MTO. This indicates whether the DL # provided is valid or invalid with 'Y' and 'N' values, respectively. A third value, 'O,' indicates the license was issued outside of Texas and is not validated by TMTS. A fourth value, 'X,' indicates the license is required, but no license is included on the record

3. MT88 MTO Processing

The MT88 file is validated through business edits. All MT88 business edits are set up as Fatal, and therefore any provider record which does not pass these edits will be rejected. Records that pass this business validation process will be accepted by TMHP systems. All failures are reported to the MTO by TMHP through MT88 Provider Network Error file. TMHP expects the MTO to correct any errors and resubmit the record.

4. MT88 MTO Business Edits

Edit Code	MT88 MTO Data Element(s)	Field in Error	Error Description (Short)	Edit Disposition	Validation
MT88001FTA	MTO Plan Code	MTO Plan Code	Record plan code is invalid.	Fatal	Plan Code does not match code in file name.
MT88002FTA	Provider ID	Provider ID	Provider ID is missing.	Fatal	Provider ID is blank
MT88003FTA	Provider ID	Provider ID	MTI in Provider ID is in invalid format.	Fatal	When Provider ID begins with "T" and one or more of the following is true: Positions 2-3 do not match Plan Code element in record Positions 4-10 are not digits
MT88004FTA	Provider ID	Provider ID	NPI or API in Provider ID is not enrolled with TMHP.	Fatal	Provider ID is not MTI and Provider ID does not match to an NPI/API enrolled with TMHP.

Edit Code	MT88 MTO Data Element(s)	Field in Error	Error Description (Short)	Edit Disposition	Validation
MT88005FTA	TPI	TPI	TPI does not match enrolled provider type at TMHP.	Fatal	Provider ID is not MTI and Provider Type on MT88 file does not match to Provider Type enrolled for this TPI in TMHP systems.
MT88006FTA	TPI	TPI	TPI does not match provider specialty at TMHP.	Fatal	Provider ID is not MTI and Provider Specialty on MT88 file does not match to Provider Specialty enrolled for this TPI in TMHP systems.
MT88007FTA	TPI	TPI	TPI is missing.	Fatal	Provider ID is NPI or API and TPI is blank.
MT88008FTA	TPI	TPI	TPI is invalid.	Fatal	TPI on MT88 file does not match TPI in TMHP systems.
MT88010FTA	Last Name/Org Name	Last Name/Org Name	Last name or organization name is missing.	Fatal	Last Name or Organization Name is blank.
MT88011FTA	Address Line 1	Address Line 1	Address Line 1 is missing.	Fatal	Address line 1 is blank.
MT88012FTA	City	City	City is missing.	Fatal	City is blank.
MT88013FTA	State	State	State is missing.	Fatal	State is blank.
MT88014FTA	ZIP	ZIP	ZIP code is missing or incomplete.	Fatal	One of the following is true: ZIP Code is blank. Value in ZIP Code field on file is less than 5 characters in length First 5 characters are "0"
MT88015FTA	County Code	County Code	County code is missing.	Fatal	County Code is blank.
MT88016FTA	Gender	Gender	Gender code is missing or invalid value.	Fatal	One of the following is true: Gender code is blank Gender code is not "M" or "F" or "U"
MT88017FTA	Phone Number	Phone Number	Phone number is missing.	Fatal	Phone Number is blank.
MT88018FTA	Provider Type	Provider Type	Provider type is invalid or missing.	Fatal	Provider Type is not "MT."

Edit Code	MT88 MTO Data Element(s)	Field in Error	Error Description (Short)	Edit Disposition	Validation
MT88019FTA	Specialty Code	Specialty Code	MTP Provider specialty is invalid or missing.	Fatal	One of the following is true: Provider ID is MTI and Specialty Code is one of the following values: TR - Demand Response MTO Waiver TS - Demand Response Subcontractor TT - Broker Provider ID is not MTI and Specialty Code is one of the following values: TD - Demand Response Subcontractor Driver TZ - Demand Response MTO Driver Waiver T2 - Airline Travel T3 - Intercity Bus (Greyhound) T4 - Individual Transportation Participant (ITP) T6 - Lodging T7 - Mass Transit T8 - Meals Provider Specialty Code is not one of the values in the previous lists.
MT88020FTA	TIN	TIN	Tax ID or SSN is missing.	Fatal	Tax ID Number is blank.
MT88021FTA	Specialty, Date of Birth	Date of Birth	Date of Birth is missing or invalid.	Fatal	Provider ID is MTI, Specialty Code is "TD" or "T4" or "TZ" and Date of Birth is blank.
MT88022FTA	Specialty, Date of Death	Date of Death	Date of Death is missing or invalid.	Fatal	Provider ID is MTI, Specialty Code is "TD" or "T4" or "TZ" and Date of Death is blank.
MT88023FTA	Effective Date	Effective Date	Effective date is missing.	Fatal	Effective Date is blank
MT88024FTA	Effective Date, Terminate Date	Terminate Date	Terminate date is earlier than effective date.	Fatal	Terminate Date < Effective Date
MT88025FTA	Provider ID, Effective Date	Effective Date	Effective date is earlier than 60 days from file date on ADD.	Fatal	The record meets the following criteria: Provider ID is not already in TMHP system as an Active provider and Effective Date < File Date on MT88 file minus 60 days

Edit Code	MT88 MTO Data Element(s)	Field in Error	Error Description (Short)	Edit Disposition	Validation
MT88026FTA	Effective Date	Effective Date	Effective date is over 30 days in the future.	Fatal	Effective Date > 30 days from file process date
MT88027FTA	Terminate Date	Terminate Date	Terminate date is earlier than effective date of active record.	Fatal	Terminate Date < Effective Date in TMHP system
MT88028FTA	Specialty, First Name	First Name	First name is missing.	Fatal	Provider ID is MTI, Provider Specialty Code is “T4” or "TD" or "TZ" and First Name is blank.
MT88029FTA	Specialty, DL State	DL State	Driver’s license state is missing.	Fatal	Provider ID is MTI, Provider Specialty Code is “T4” or "TD" or "TZ" and Driver’s License State is blank.
MT88030FTA	Specialty, DL #	DL #	Driver’s license number is missing.	Fatal	Provider ID is MTI, Provider Specialty Code is “T4” or "TD" or "TZ" and Driver’s License Number is blank.
MT88031FTA	Effective Date	Effective Date	Effective date does not match active record.	Fatal	Effective Date does not match previously submitted/accepted effective date.
MT88032FTA	Taxonomy Code	Taxonomy Code	Taxonomy Code is missing.	Fatal	Taxonomy Code is blank
MT88033FTA	Taxonomy Code, Provider Specialty	Taxonomy Code	Taxonomy Code is invalid for provided Specialty.	Fatal	See list of valid Taxonomy codes in Section 2 above.
MT88034FTA	DL Validity Indicator	DL Validity Indicator	Driver's License required and not provided.	Fatal	DL Validity Indicator = 'X'
MT88035FTA	Specialty Code	Specialty Code	Provider Specialty does not match	Fatal	Provider ID is MTI and Provider Specialty code does not match previously submitted Provider Specialty

5. MT88 MTO Provider Network Error File Layout

The MT88 Provider Network Error file is generated each time an MT88 file is processed with errors. The file is delivered in TxMedCentral one business day after the MT88 file completes processing at Accenture under *LIB folder for the region of the MT88 file.

Submission Frequency: Available by 9 AM CST the day after TMHP processes MT88 (only created when MT88 processed with errors)

Sender: TMHP via TXMEDCENTRAL to the MTO *LIB folder

Receivers: MTO

File Naming Convention: pp000_MT88_PRV_ERR_jjj.csv

- pp = Plan Code
- jjj = Julian Date

File Layout:

Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Comments
1	MT88 File Name	61	1	61	CHAR	Name of the inbound data file that contained the error
2	MT88 File Date	11	62	72	DATE	Date that the inbound data file was processed. Format: YYYY-MM-DD
3	Record Number	34	73	106	CHAR	Row number that contained the error
4	Error Number	21	107	127	CHAR	Which error (business edit) was triggered
5	Error Description	251	128	378	CHAR	Description of error code
6	Field Name	41	379	419	CHAR	Which field within the row contained the error
7	Field Value	250	420	669	CHAR	Erroneous value within the source file
8	ProviderID	9	670	679	CHAR	NPI or MTI of provider record that generated the error
9	LINE FEED	1	680	680	CHAR	

6. MT88 MTO Provider Network Data Extract

The MT88 MTO Provider Network data extract contains details of the most recent MT88 provider network record accepted by TMHP to help the MTOs keep their provider records in sync with TMHP. The data extract is generated weekly and delivered in TXMedCentral Production environment under *LIB folder for the region of the MT88 file.

Submission Frequency: Available by 9 AM CST every Sunday

Sender: TMHP via TXMEDCENTRAL to the MTO *LIB folder

Receivers: MTO

File Naming Convention: PCPNF_YYYYMMDD.txt

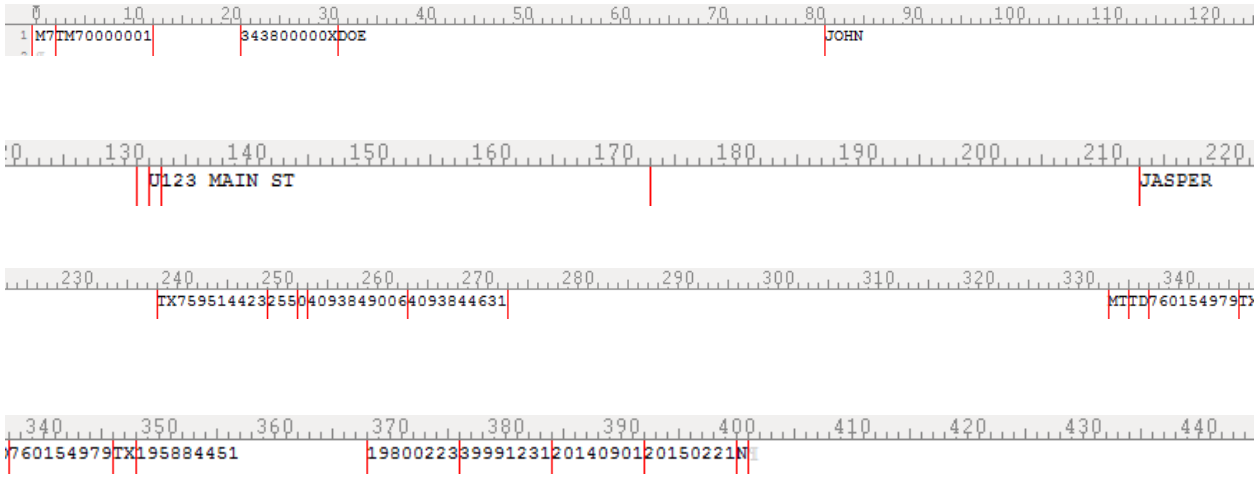
- PC = Plan Code
- PNF = Fixed value to represent Provider Network File
- YYMMDD = File creation date

File Layout:

Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Comments
1	Provider NPI/MTI	10	1	10	CHAR	NPI or MTI of Provider
2	First Name	50	11	60	CHAR	The given name, or forename, of an individual
3	Last Name	50	61	110	CHAR	The surname of an individual or the company name of an organization
4	Effective Date	8	111	118	DATE	Provider Effective Date
5	Termination Date	8	119	126	DATE	Provider Termination Date
6	Specialty Code	4	127	130	CHAR	Provider Specialty Code
7	Plan Code	2	131	132	CHAR	Provider Plan Code
8	Provider TPI Base	18	133	150	CHAR	Provider TPI Base (if available)
9	Provider TPI Suffix	2	151	152	CHAR	Provider TPI Suffix (if available)

7. Appendices

7.1 Appendix A: MT88 Example Provider Record



7.2 Appendix B:Summary of Version Changes

The following is a log of changes made since the original version of the document was published.

No	Change	Date
1.0	Initial Version	09/26/2016
2.0	Updated MT88 Error File JIP layout	10/31/2016
3.0	Added Section for MT88 MTO Provider Network Data Extract	01/27/2017

EXHIBIT J

CONTRACTOR will utilize the MTO Financial Statistical Report (FSR) Template and instructions included in the RFP and/or as clarified or further required in this Agreement until HHSC updates the Financial Statistical Report (FSR) template and instructions as provided under Section 1.10.01(e) of this Agreement.

HHSC anticipates that updates will be provided in time for CONTRACTOR to prepare State Fiscal Year 2015 first quarter financial reports (FSRs).

Attachment J FSR.xls

HHSC Financial Statistical Report (FSR) for the Medical Transportation Program

Quick Start instructional overview

This overview is primarily meant for first-time users of HHSC's FSR financial reporting templates. A more detailed and comprehensive set of instructions will be provided separately. In the event of any contradictions between that set of FSR Instructions and this overview, that set of instructions shall prevail. *Note that a number of tabs in this FSR do not require any input from the MTO.*

All entities under contract with HHSC for capitated full-risk programs, including all Managed Transportation Organizations and Full Risk Brokers, are required to submit FSRs to HHSC. FSRs are submitted Quarterly and after year-end, and financial penalties may be assessed for late, incomplete, or improper reporting. Substantial interest and/or penalties may be incurred by the MTO for mis-reporting.

Step 1. **File naming convention.**

Save a separate copy of the FSR template for each submission. Before you input anything, rename and save the MS Excel file in a format similar to this:

FSR - MTP - Region # - SFY#, Qtr#.xlsx

Example: FSR - MTP - Region 01 - SFY15, Qtr1.xlsx

If any contractor has more than one Region, then a separate report, and thus a separate spreadsheet file, must be submitted for each Region. If you submit a revised report, add REVISED to the end of the file name.

Step 2. **Organizational name, Region, timing.**

Go to the green tab labeled "1 Capitation pmts". In the first row, input your organization's legal name by selecting it from the drop down menu. In the second row, do likewise for your Region. In the third row, select the State Fiscal Year, and the Quarter, for which you are reporting. For example, under the State Fiscal Year (SFY), the first Quarter is always Sept 1st through Nov 30th. In the next two rows, input the date which you submit the report to HHSC, and the date through which the last services under this report were rendered (usually the last calendar day of the state fiscal Quarter). Once you have done the items above, they will be copied to all other tabs in the report.

Step 3. **Number of beneficiaries**

On the same tab, enter on spreadsheet row 12 (FSR form Line Item #7) the number of Adult beneficiaries in your Region for the first month under the appropriate monthly column, and also the number of beneficiaries for any other months in that reporting Quarter. The number will be reported to you by HHSC in the enrollment files you receive. The number generally varies somewhat from month to month. Row 12 is specifically for beneficiaries classified by HHSC as being in the "Adults" risk group, and who are also living in a county that has been designated as urban by HHSC. If your Region is entirely designated as rural counties, you would put zero in the urban line.

Step 4. **Payment amount from HHSC, per beneficiary, per month**

On the next row, in the first column, enter the official monthly capitation payment per member per month that has been set by HHSC for this risk group. Enter it in the September column even if you had no business under this contract during Sept. This rate usually stays the same for the entire SFY for each risk group. There may or may not be different rates for urban vs. rural.

Step 5. **Calculating total aggregate revenues from HHSC for the period**

Continue as above for all risk groups and months under this report. Note that in the far right-hand column, you will find the year-to-date amount (for the SFY) for each line item, and down below you will see the totals for the various line items combined. Note that certain cells in the spreadsheet are protected (for example, where there are forumlas to add totals, etc.).

You are only to input data in the unprotected cells, which are generally the tan-shaded cells which are empty. When you input something into these cells, the input data usually shows as blue font.

Protected cells generally show as black font; they are often unshaded, and sometimes shaded with gray for visual emphasis. Also note that the FSR Line Item numbers in spreadsheet column A are **bold red** for rows which require data input, and are black for rows which do not require input.

Step 6. **Direct Client Services Costs**

Operating costs for services provided to beneficiares will be entered in the yellow tabs (beginning with "2a Adults Urban"), labeled as 2a through 2f; each tab corresponds to a single risk group (as shown under the green "1 Capitation pmts" tab). If all counties in your Region are classified as rural counties by HHSC, you will only use the tabs marked Rural (tabs 2b, 2d, and 2f). Other Regions may use all the yellow tabs. Costs entered in the yellow tabs do *not* include any administrative overhead costs (eg, no costs for call centers, etc); those costs go in another tab.

All costs entered in the yellow tabs are aggregate *per-service* costs. No salaries, facility costs, etc., are entered here. The amounts paid by the MTO for beneficiary meals, along with the quantity of meals, are entered here; likewise for lodging, mass transit bus, and airline. It is no different for demand response. Each demand response trip has a charged cost attributable to that specific trip, and each of those trip costs, along with the corresponding number of trips and distance in miles, is entered.

If your organization utilizes any owned transportation, the specific trip charges assessed for any rides provided by owned transportation and/or employed drivers must be entered in the "Demand Response - Affiliate" row. Normal unaffiliated third-party purchased transportation is entered in the "Demand Response - Non-affiliate" row. HHSC will implement limits for the amount that can be charged for Affiliate demand response trips. In no case will driver wages, vehicle maintenace costs, gas, depreciation, etc., be entered anywhere in this report. Costs for any Affiliate transportation must be entred in terms of *per-trip* fees, along with the corresponding number of trips and the distance in miles.

Step 7. **Administrative Overhead Costs**

Costs for administrating the program are entered in the three orange tabs, tabs 3a through 3c (beginning with "3a Admin - Unaffil"). Note that *no* transportation-related costs are to be input in the Admin cost tabs.

Admin costs are divided between those paid directly by the legal entity that contracts with HHSC, vs. those that may be assessed to the MTO by the MTO's parent or other Affiliate. The first two tabs in this section, 4a and 4b, reflect this split. For example, a staff member whose W2 reflects the "employer" as being the same legal entity that holds the contract with HHSC (ie, the MTO), would be shown in the "Payments to unaffiliated parties" section, while a staff member whose W2 shows the parent's name (or the name of another Affiliate) would be shown under the "payments to Affiliated parties" section (since the MTO will have to in turn pay the parent or other Affiliate for these salaries). Likewise for rent, professional services fees, etc. If the MTO itself directly cuts a check to every employee and entity paid, and there are no payments to, or corporate assessments of any kind from, a parent or other Affiliate, then all of the MTOs admin would go in the "payments to unaffiliated parties" area. Be sure to refer to HHSC's Cost Principles for specific rules on allowable costs for inclusion in this FSR.

The third tab in this section, 4c, is a breakdown of the combined total salaries (incl benefits) by functional area (eg, how much is for operating an internal call center, vs. for accounting, etc.).

Step 8. **Total Summary Income Statement**

The next tab, in red, labled "4 Summary Inc Stmt," brings together data from the prior tabs, and shows the net income before taxes (as defined by HHSC) attributable to this Region under the contract with HHSC for this time period. There is very little input on this tab, but there are a few items, including any interest income earned off the float from the HHSC capitation pre-payments, and down at the bottom, any Liquidated Damages fines paid to HHSC by the MTO.

Step 9. **Sign-off for data certification**

The next tab, also in red, labled "5 Certification," is a required sign-off that the data is accurate and done in accordance with HHSC's contract rules (primarily The Cost Principles). This must be signed by the MTO's CEO or CFO, or the person holding the equivalent title within the MTO (ie, the MTO's top executive officer, or top financial officer). This sign-off cannot be delegated down. The MTO should print this tab, manually sign it, scan the signed original into a pdf file, and send the pdf to HHSC along with the FSR xls file. Be sure to update the "Submission Date" on row 4 in the "1 Capitation pmts" tab before saving the xls file for submission to HHSC.

Step 10. **Review of other summary data (optional)**

No tabs past the "5 Certification" tab require any input from the MTO. The tab labeled "scratch sheet" is entirely unprotected, and may be used by the MTO for any purpose, if desired. For example, you may have certain financial data that is generated by your internal system that comes in a certain format; you could do a data dump in your own format on this tab, and then reference cells in the tab by formula in other tabs, which could save time in filling in the form for subsequent submissions.

The "6 Doc History Log" will show descriptions of changes in subsequent versions of the spreadsheet. The remaining tabs, labeled 7a through 7d, show various data summaries generated by the data input in prior tabs. HHSC utilizes these tabs for analysis, and the MTO may find this useful, as well.

Contractor name:
Region:
State Fiscal Year: **2015** Submission Type: Qtr 1
Submission Date: December 31, 2014
Accrual Date: November 30, 2014

State of Texas, Health & Human Services Commission
Medical Transportation Program - Managed Transportation Organization Contract
FINANCIAL STATISTICAL REPORT (FSR)
Contractor s self-reported data must be in compliance with the MTP Cost Principles.
Reporting is on an incurred basis and all numbers are subject to audit by HHSC or its designee.

printed: 8/17/2017

Version # **1.0**

Page 1: Premium Payment System

Monthly payments from HHSC to the MTO.

	2014			2014	2015							2015	
Incurred Months:	September	October	November	December	January	February	March	April	May	June	July	August	**YTD**
# of Enrollees (members) - ADULTS, urban													***0***
Capitation rate, per Contract ($-PMPM)		$0.00	$0.00	$0 00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**n/a**
Capitation premium payment - ADULTS, urban	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
# of Enrollees (members) - ADULTS, rural													***0***
Capitation rate, per Contract ($-PMPM)	$0 00	$0.00	$0.00	$0 00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**n/a**
Capitation premium payment - ADULTS, rural	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
Capitation premium payment - ADULTS (total)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
# of Enrollees (members) - CHILDREN, urban													***0***
Capitation rate, per Contract ($-PMPM)		$0.00	$0.00	$0 00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**n/a**
Capitation premium payment - CHILDREN, urban	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
# of Enrollees (members) - CHILDREN, rural													***0***
Capitation rate, per Contract ($-PMPM)	$0 00	$0.00	$0.00	$0 00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**n/a**
Capitation premium payment - CHILDREN, rural	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
Capitation premium payment - CHILDREN (total)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
# of Enrollees - CSHCN, urban													***0***
Capitation rate, per Contract ($-PMPM)		$0.00	$0.00	$0 00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**n/a**
Capitation premium payment - CSHCN, urban	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
# of Enrollees - CSHCN, rural													***0***
Capitation rate, per Contract ($-PMPM)	$0 00	$0.00	$0.00	$0 00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**n/a**
Capitation premium payment - CSHCN, rural	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
Capitation premium payment - CSHCN (total)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
Total HHSC Premium Payments to MTO	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Total # of Enrollees	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
Average Capitation Mix (Total PPS $ per Mbr)	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
Rural / urban mix (incls all risk groups):													
Capitation $ Mix: % **rural** $ to total $	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	***n/a***
# of Enrollees *Mix: % **rural** mbrs to total mbrs*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	**n/a**
Risk Group mix (incls. urban and rural):													
Capitation Mix: % of ADULT $ to Total PPS $	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
Capitation Mix: % of CHILDREN $ to Total PPS $	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
Enrollee Mix: % of ADULTs to Total Mbrs	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	***n/a***
Enrollee Mix: % of CHILDREN to Total Mbrs	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	***n/a***

Contractor name: **0**
Region: **0**
State Fiscal Year: **2015** Submission Type: Qtr 1
Submission Date: December 31, 2014
Accrual Date: November 30, 2014

State of Texas, Health & Human Services Commission
Medical Transportation Program - Managed Transportation Organization Contract
FINANCIAL STATISTICAL REPORT (FSR)
Contractor s self-reported data must be in compliance with the MTP Cost Principles.
Reporting is on an incurred basis and all numbers are subject to audit by HHSC or its designee.

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Version # 1.0

Page 2a: Client Services - ADULTS, Urban

DIRECT CLIENT TRANSPORTATION, MEALS, & LODGING COSTS, EXCLUDING ADMINISTRATIVE OVERHEAD

		2014			2014	2015							2015	
	Incurred Months:	September	October	November	December	January	February	March	April	May	June	July	August	YTD
1	***# of Enrollees (Members)***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
	Aggregate Client Services Operating Costs													
2	Demand Response - Non-Affiliate													**$0**
3	Demand Response - Affiliate													**$0**
4	Mileage (reimbursement or pre-paid)													**$0**
5	Mass Transit - Bus													**$0**
6	Air													**$0**
7	*Aggregate Paid Transportation Costs*	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
8	Lodging													**$0**
9	Meals (reimbursement or pre-paid)													**$0**
10	Accruals													**$0**
11	**Total Client Service Operating Costs**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
12	**$PMPM - ADULTS, URBAN** *(excludes Admin Costs)*	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***
	Number of Client Services Trips													
13	Demand Response - Non-Affiliate													**0**
14	Demand Response - Affiliate													**0**
15	Mileage (reimbursement or pre-paid)													**0**
16	Mass Transit - Bus													**0**
17	Air													**0**
18	*Total Number of Transportation Trips*	0	0	0	0	0	0	0	0	0	0	0	0	**0**
19	# of Lodging Nights													**0**
20	# of Meals													**0**
	Number of Miles													
21	Demand Response - Non-Affiliate													**0**
22	Demand Response - Affiliate													**0**
23	Mileage (reimbursement or pre-paid)													**0**
24	*Total Miles (excluding Bus and Air)*	0	0	0	0	0	0	0	0	0	0	0	0	0
25	**accruals** as **%** of pd. Op. Costs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
26	Cash advances / pre-pmts incl. above													**$0**
	Operating Costs per Trip (excl Admin)													
27	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
28	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
29	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
30	Mass Transit - Bus	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
31	***Avg Op Cost / ground trip*** *(excl Admin)*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
32	Air - cost per trip	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
33	cost per Lodging Night	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
34	cost per Meal	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
	Average Miles per Trip													
35	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
36	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
37	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
38	*Avg* ***Miles per Trip*** *(excl Bus & Air)*	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
	Average Cost per Mile (excl Admin)													
39	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
40	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
41	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
42	*Avg* ***Cost per Mile*** *(excl Bus & Air)*	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
	associated Administrative costs (not included above)													
43	total MTO Admin % to Op. Costs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
44	allocated risk group Admin cost $	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
45	- implied risk group **Admin $-PMPM**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**

Contractor name: **0**
Region: **0**
State Fiscal Year: **2015** Submission Type: Qtr 1
Submission Date: December 31, 2014
Accrual Date: November 30, 2014

State of Texas, Health & Human Services Commission
Medical Transportation Program - Managed Transportation Organization Contract
FINANCIAL STATISTICAL REPORT (FSR)
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Page 2a: Client Services - ADULTS, Urban

DIRECT CLIENT TRANSPORTATION, MEALS, & LODGING COSTS, EXCLUDING ADMINISTRATIVE OVERHEAD

		2014			2014	2015							2015	
	Incurred Months:	September	October	November	December	January	February	March	April	May	June	July	August	**YTD**
46	- implied risk group **Admin $ per trip**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**

Contractor name: **0**
Region: **0**
State Fiscal Year: **2015** Submission Type: Qtr 1
Submission Date: December 31, 2014
Accrual Date: November 30, 2014

State of Texas, Health & Human Services Commission
Medical Transportation Program - Managed Transportation Organization Contract
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Page 2b: Client Services - ADULTS, Rural

DIRECT CLIENT TRANSPORTATION, MEALS, & LODGING COSTS, EXCLUDING ADMINISTRATIVE OVERHEAD

		2014			2014	2015							2015	
	Incurred Months:	September	October	November	December	January	February	March	April	May	June	July	August	YTD
1	***# of Enrollees (Members)***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
	Aggregate Client Services Operating Costs													
2	Demand Response - Non-Affiliate													**$0**
3	Demand Response - Affiliate													**$0**
4	Mileage (reimbursement or pre-paid)													**$0**
5	Mass Transit - Bus													**$0**
6	Air													**$0**
7	*Aggregate Paid Transportation Costs*	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
8	Lodging													**$0**
9	Meals (reimbursement or pre-paid)													**$0**
10	Accruals													**$0**
11	**Total Client Service Operating Costs**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
12	**$PMPM - CHILDREN, URBAN (excludes Admin Costs)**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
	Number of Client Services Trips													
13	Demand Response - Non-Affiliate													**0**
14	Demand Response - Affiliate													**0**
15	Mileage (reimbursement or pre-paid)													**0**
16	Mass Transit - Bus													**0**
17	Air													**0**
18	*Total Number of Transportation Trips*	0	0	0	0	0	0	0	0	0	0	0	0	**0**
19	# of Lodging Nights													**0**
20	# of Meals													**0**
	Number of Miles													
21	Demand Response - Non-Affiliate													**0**
22	Demand Response - Affiliate													**0**
23	Mileage (reimbursement or pre-paid)													**0**
24	*Total Miles (excluding Bus and Air)*	0	0	0	0	0	0	0	0	0	0	0	0	0
25	accruals as % of pd. Op. Costs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
26	Cash advances / pre-pmts incl. above													**$0**
	Operating Costs per Trip (excl Admin)													
27	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
28	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
29	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
30	Mass Transit - Bus	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
31	***Avg Op Cost / ground trip (excl Admin)***	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
32	Air - cost per trip	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
33	cost per Lodging Night	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
34	cost per Meal	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
	Average Miles per Trip													
35	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
36	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
37	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
38	*Avg Miles per Trip (excl Bus & Air)*	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
	Average Cost per Mile (excl Admin)													
39	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
40	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
41	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
42	*Avg Cost per Mile (excl Bus & Air)*	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
	associated Administrative costs (not included above)													
43	total MTO Admin % to Op. Costs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
44	allocated risk group Admin cost $	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
45	- implied risk group **Admin $-PMPM**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
46	- implied risk group **Admin $ per trip**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**

Contractor name: **0**
Region: **0**
State Fiscal Year: **2015** Submission Type: Qtr 1
Submission Date: December 31, 2014
Accrual Date: November 30, 2014

State of Texas, Health & Human Services Commission
Medical Transportation Program - Managed Transportation Organization Contract
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Page 2c: Client Services - CHILDREN, Urban

DIRECT CLIENT TRANSPORTATION, MEALS, & LODGING COSTS, EXCLUDING ADMINISTRATIVE OVERHEAD

		2014			2014	2015						2015		
	Incurred Months:	September	October	November	December	January	February	March	April	May	June	July	August	YTD
1	***# of Enrollees (Members)***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
	Aggregate Client Services Operating Costs													
2	Demand Response - Non-Affiliate													**$0**
3	Demand Response - Affiliate													**$0**
4	Mileage (reimbursement or pre-paid)													**$0**
5	Mass Transit - Bus													**$0**
6	Air													**$0**
7	*Aggregate Paid Transportation Costs*	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
8	Lodging													**$0**
9	Meals (reimbursement or pre-paid)													**$0**
10	Accruals													**$0**
11	**Total Client Service Operating Costs**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
12	**$PMPM - CHILDREN, URBAN** *(excludes Admin Costs)*	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***
	Number of Client Services Trips													
13	Demand Response - Non-Affiliate													**0**
14	Demand Response - Affiliate													**0**
15	Mileage (reimbursement or pre-paid)													**0**
16	Mass Transit - Bus													**0**
17	Air													**0**
18	*Total Number of Transportation Trips*	0	0	0	0	0	0	0	0	0	0	0	0	**0**
19	# of Lodging Nights													**0**
20	# of Meals													**0**
	Number of Miles													
21	Demand Response - Non-Affiliate													**0**
22	Demand Response - Affiliate													**0**
23	Mileage (reimbursement or pre-paid)													**0**
24	*Total Miles (excluding Bus and Air)*	0	0	0	0	0	0	0	0	0	0	0	0	0
25	**accruals** as **%** of pd. Op. Costs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
26	Cash advances / pre-pmts incl. above													**$0**
	Operating Costs per Trip (excl Admin)													
27	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
28	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
29	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
30	Mass Transit - Bus	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
31	***Avg Op Cost / ground trip*** *(excl Admin)*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
32	Air - cost per trip	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
33	cost per Lodging Night	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
34	cost per Meal	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
	Average Miles per Trip													
35	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
36	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
37	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
38	*Avg* ***Miles per Trip*** *(excl Bus & Air)*	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
	Average Cost per Mile (excl Admin)													
39	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
40	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
41	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
42	*Avg* ***Cost per Mile*** *(excl Bus & Air)*	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
	associated Administrative costs (not included above)													
43	total MTO Admin % to Op. Costs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
44	allocated risk group Admin cost $	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**

Contractor name: **0**
Region: **0**
State Fiscal Year: **2015** Submission Type: Qtr 1
Submission Date: December 31, 2014
Accrual Date: November 30, 2014

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Page 2c: Client Services - CHILDREN, Urban

DIRECT CLIENT TRANSPORTATION, MEALS, & LODGING COSTS, EXCLUDING ADMINISTRATIVE OVERHEAD

		2014			2014	2015							2015	
	Incurred Months:	September	October	November	December	January	February	March	April	May	June	July	August	**YTD**
45	- implied risk group **Admin $-PMPM**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
46	- implied risk group **Admin $ per trip**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**

Contractor name: 0
Region: 0
State Fiscal Year: 2015 Submission Type: Qtr 1
Submission Date: December 31, 2014
Accrual Date: November 30, 2014

State of Texas, Health & Human Services Commission
Medical Transportation Program - Managed Transportation Organization Contract
FINANCIAL STATISTICAL REPORT (FSR)
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Page 2d: Client Services - CHILDREN, Rural

DIRECT CLIENT TRANSPORTATION, MEALS, & LODGING COSTS, EXCLUDING ADMINISTRATIVE OVERHEAD

		2014			2014	2015							2015	
	Incurred Months:	September	October	November	December	January	February	March	April	May	June	July	August	YTD
1	***# of Enrollees (Members)***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
	Aggregate Client Services Operating Costs													
2	Demand Response - Non-Affiliate													**$0**
3	Demand Response - Affiliate													**$0**
4	Mileage (reimbursement or pre-paid)													**$0**
5	Mass Transit - Bus													**$0**
6	Air													**$0**
7	*Aggregate Paid Transportation Costs*	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
8	Lodging													**$0**
9	Meals (reimbursement or pre-paid)													**$0**
10	Accruals													**$0**
11	**Total Client Service Operating Costs**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
12	**$PMPM - CHILDREN, URBAN (excludes Admin Costs)**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
	Number of Client Services Trips													
13	Demand Response - Non-Affiliate													**0**
14	Demand Response - Affiliate													**0**
15	Mileage (reimbursement or pre-paid)													**0**
16	Mass Transit - Bus													**0**
17	Air													**0**
18	*Total Number of Transportation Trips*	0	0	0	0	0	0	0	0	0	0	0	0	**0**
19	# of Lodging Nights													**0**
20	# of Meals													**0**
	Number of Miles													
21	Demand Response - Non-Affiliate													**0**
22	Demand Response - Affiliate													**0**
23	Mileage (reimbursement or pre-paid)													**0**
24	*Total Miles (excluding Bus and Air)*	0	0	0	0	0	0	0	0	0	0	0	0	0
25	accruals as % of pd. Op. Costs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
26	Cash advances / pre-pmts incl. above													**$0**
	Operating Costs per Trip (excl Admin)													
27	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
28	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
29	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
30	Mass Transit - Bus	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
31	***Avg Op Cost / ground trip (excl Admin)***	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
32	Air - cost per trip	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
33	cost per Lodging Night	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
34	cost per Meal	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
	Average Miles per Trip													
35	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
36	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
37	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
38	*Avg Miles per Trip (excl Bus & Air)*	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
	Average Cost per Mile (excl Admin)													
39	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
40	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
41	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
42	*Avg Cost per Mile (excl Bus & Air)*	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
	associated Administrative costs (not included above)													
43	total MTO Admin % to Op. Costs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
44	allocated risk group Admin cost $	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
45	- implied risk group **Admin $-PMPM**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
46	- implied risk group **Admin $ per trip**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**

Contractor name: 0
Region: 0
State Fiscal Year: 2015 Submission Type: Qtr 1
Submission Date: December 31, 2014
Accrual Date: November 30, 2014

State of Texas, Health & Human Services Commission
Medical Transportation Program - Managed Transportation Organization Contract
FINANCIAL STATISTICAL REPORT (FSR)
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Page 2e: Client Services - Special Populations, Urban

DIRECT CLIENT TRANSPORTATION, MEALS, & LODGING COSTS, EXCLUDING ADMINISTRATIVE OVERHEAD

includes Children with Special Health Care Needs (all ages), TCIP where applicable, and other groups as may be defined by HHSC

	Incurred Months:	2014 September	October	November	2014 December	2015 January	February	March	April	May	June	July	2015 August	YTD
1	***# of Enrollees (Members)***	0	0	0	0	0	0	0	0	0	0	0	0	0
	Aggregate Client Services Operating Costs													
2	Demand Response - Non-Affiliate													$0
3	Demand Response - Affiliate													$0
4	Mileage (reimbursement or pre-paid)													$0
5	Mass Transit - Bus													$0
6	Air													$0
7	*Aggregate Paid Transportation Costs*	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
8	Lodging													$0
9	Meals (reimbursement or pre-paid)													$0
10	Accruals													$0
11	**Total Client Service Operating Costs**	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
12	**$PMPM - CSHCN, URBAN** *(excludes Admin Costs)*	#DIV/0	#DIV/0	#DIV/0	#DIV/0	#DIV/0	#DIV/0	#DIV/0	#DIV/0	#DIV/0	#DIV/0	#DIV/0	#DIV/0	#DIV/0
	Number of Client Services Trips													
13	Demand Response - Non-Affiliate													0
14	Demand Response - Affiliate													0
15	Mileage (reimbursement or pre-paid)													0
16	Mass Transit - Bus													0
17	Air													0
18	*Total Number of Transportation Trips*	0	0	0	0	0	0	0	0	0	0	0	0	0
19	# of Lodging Nights													0
20	# of Meals													0
	Number of Miles													
21	Demand Response - Non-Affiliate													0
22	Demand Response - Affiliate													0
23	Mileage (reimbursement or pre-paid)													0
24	*Total Miles (excluding Bus and Air)*	0	0	0	0	0	0	0	0	0	0	0	0	0
25	**accruals** as **%** of pd. Op. Costs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
26	Cash advances / pre-pmts incl. above													$0
	Operating Costs per Trip (excl Admin)													
27	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
28	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
29	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
30	Mass Transit - Bus	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
31	***Avg Op Cost / ground trip*** *(excl Admin)*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
32	Air - cost per trip	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
33	cost per Lodging Night	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
34	cost per Meal	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Average Miles per Trip													
35	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
36	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
37	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
38	*Avg **Miles per Trip** (excl Bus & Air)*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Average Cost per Mile (excl Admin)													
39	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
40	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
41	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
42	*Avg **Cost per Mile** (excl Bus & Air)*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	associated Administrative costs (not included above)													
43	total MTO Admin % to Op. Costs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
44	allocated risk group Admin cost $	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
45	- implied risk group **Admin $-PMPM**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
46	- implied risk group **Admin $ per trip**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Contractor name: 0
Region: 0
State Fiscal Year: 2015 Submission Type: Qtr 1
Submission Date: December 31, 2014
Accrual Date: November 30, 2014

State of Texas, Health & Human Services Commission
Medical Transportation Program - Managed Transportation Organization Contract
FINANCIAL STATISTICAL REPORT (FSR)
Contractor s self-reported data must be in compliance with the MTP Cost Principles.
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Version # 1.0

Page 2f: Client Services - Special Populations, Rural

DIRECT CLIENT TRANSPORTATION, MEALS, & LODGING COSTS, EXCLUDING ADMINISTRATIVE OVERHEAD

includes Children with Special Health Care Needs (all ages), TCIP where applicable, and other groups as may be defined by HHSC

		2014			2014	2015							2015	
	Incurred Months:	September	October	November	December	January	February	March	April	May	June	July	August	YTD
1	***# of Enrollees (Members)***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
	Aggregate Client Services Operating Costs													
2	Demand Response - Non-Affiliate													**$0**
3	Demand Response - Affiliate													**$0**
4	Mileage (reimbursement or pre-paid)													**$0**
5	Mass Transit - Bus													**$0**
6	Air													**$0**
7	*Aggregate Paid Transportation Costs*	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
8	Lodging													**$0**
9	Meals (reimbursement or pre-paid)													**$0**
10	Accruals													**$0**
11	**Total Client Service Operating Costs**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
12	**$PMPM - CHILDREN, URBAN (excludes Admin Costs)**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
	Number of Client Services Trips													
13	Demand Response - Non-Affiliate													**0**
14	Demand Response - Affiliate													**0**
15	Mileage (reimbursement or pre-paid)													**0**
16	Mass Transit - Bus													**0**
17	Air													**0**
18	*Total Number of Transportation Trips*	0	0	0	0	0	0	0	0	0	0	0	0	**0**
19	# of Lodging Nights													**0**
20	# of Meals													**0**
	Number of Miles													
21	Demand Response - Non-Affiliate													**0**
22	Demand Response - Affiliate													**0**
23	Mileage (reimbursement or pre-paid)													**0**
24	*Total Miles (excluding Bus and Air)*	0	0	0	0	0	0	0	0	0	0	0	0	0
25	accruals as % of pd. Op. Costs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
26	Cash advances / pre-pmts incl. above													**$0**
	Operating Costs per Trip (excl Admin)													
27	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
28	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
29	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
30	Mass Transit - Bus	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
31	***Avg Op Cost / ground trip (excl Admin)***	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
32	Air - cost per trip	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
33	cost per Lodging Night	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
34	cost per Meal	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
	Average Miles per Trip													
35	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
36	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
37	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
38	*Avg Miles per Trip (excl Bus & Air)*	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
	Average Cost per Mile (excl Admin)													
39	Demand Response - Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
40	Demand Response - Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
41	Mileage (reimbursement or pre-paid)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
42	*Avg Cost per Mile (excl Bus & Air)*	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
	associated Administrative costs (not included above)													
43	total MTO Admin % to Op. Costs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
44	allocated risk group Admin cost $	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
45	- implied risk group **Admin $-PMPM**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
46	- implied risk group **Admin $ per trip**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**

Contractor name: **0**
Region: **0**
State Fiscal Year: **2015** Submission Type: Qtr 1
Submission Date: December 31, 2014
Accrual Date: November 30, 2014

State of Texas, Health & Human Services Commission
Medical Transportation Program
FINANCIAL STATISTICAL REPORT (FSR)
Contractor s self-reported data must be in compliance with the MTP Cost Principles.
Not all Admin costs are allowed for inclusion in this report. Reports will be audited.

printed: 8/17/2017

Version # **1.0**

Page 3a: Total Administrative Expenses

(continued on Page 3b)

This page for administrative overhead expenses only. Do not include transportation costs for enrollees
(See the Certification tab herein for a partial list of unallowable costs; see HHSC's Cost Principles for full definitions)

	Incurred Months:	2014 September	October	November	2014 December	2015 January	February	March	April	May	June	July	2015 August	YTD
TOTALS:														
1	Contractor Payments to Unaffiliated Parties	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
2	Contractor Payments to Affiliated Parties (HQ, parent, etc)	0	0	0	0	0	0	0	0	0	0	0	0	0
3	**Total Administrative Expenses**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
4	% of Total Admin Expenses paid to Affiliated Parties	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Note: Item 1 includes any payroll paid by Contractor directly to employees. Item 2 includes all allocations, assessments, intra-company billing/settlements, and invoices from Affiliates.
Item 2 includes any amounts paid by parent, etc., of behalf of Contractor (incl any employees paid by parent).

5 Does Item 2 contain amts from more than one entity?
If Item 5 is answered "YES" in any month, then enter additional lines below (bottom of page), one line per organiza ional entity, that add up to Item 2 above.

DETAILED BREAKDOWNS:

	Contractor Payments to Unaffiliated Parties:													
6	*Headcount* of employees pd directly by Contractor													*n/a*
7	*Sq. Ft. of ofc space* pd by Contr dir to Unaffil party													*n/a*
8	Salaries, wages, & benefits, excl. bonuses													$0
9	Bonuses													0
10	Rent, lease, or mortgage pmt for office space													0
11	Utilities (if not incl in rent), excl phone/telecom													0
12	Phone / telecom / cell phones / T1 / broadband													0
13	Equipment lease or rent (excl computer or software)													0
14	Computer hardware/software purch, uncapitalized													0
15	Furniture, fixtures, & other equip purch, uncapital'd													0
16	Maintenance, repairs, custodial, & security													0
17	Supplies, postage, freight, printing													0
18	Legal & prof services, incl ext audit, tax, consult													0
19	Travel expenses													0
20	Marketing, PR, & Outreach (excl. salaries)													0
21	Taxes (excluding income taxes) & Licensing													0
22	Insurance													0
23	Deprecia ion & amortiza ion													0
24	Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
25	Other Expenses													0
26	**Contractor Admin Payments to Unaffiliated Parties**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
27	Is Line 25 "Other" > 10% of Line 24?	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

If Line 27 is "YES" in any month, provide breakdown of Other (below)

Area to provide breakdowns of Lines 2, and/or 25, as may be required:

2		$0
2		0
		0
25		0
25		0
		0
		0
		0

Contractor name: 0
Region: 0
State Fiscal Year: 2015 Submission Type: Qtr 1
Submission Date: December 31, 2014
Accrual Date: November 30, 2014

State of Texas, Health & Human Services Commission
Medical Transportation Program
FINANCIAL STATISTICAL REPORT (FSR)
Contractor s self-reported data must be in compliance with the MTP Cost Principles.
Not all Admin costs are allowed for inclusion in this report. Reports will be audited.

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Version # 1.0

Page 3b: Total Administrative Expenses

(continued from Page 3a)

This page for administrative overhead expenses only. Do not include transportation costs for enrollees.
(See the Certification tab herein for a partial list of unallowable costs; see HHSC's Cost Principles for full definitions)

		2014			2014	2015						2015		
	Incurred Months:	September	October	November	December	January	February	March	April	May	June	July	August	YTD
	DETAILED BREAKDOWNS - continued:													
	Contractor Payments to Affiliated Parties (HQ, Parent, and/or other Affiliates													
1	*Headcount* of employees billed to Contractor													*n/a*
2	*Sq. Ft. of ofc space* billed to Contractor													*n/a*
	Items billed to Contractor by Affiliated Party or Parent													
3	Salaries, wages, & benefits, excl. bonuses													$0
4	Bonuses													0
5	Rent, lease, or mortgage pmt for office space													0
6	Utilities (if not incl in rent), excl phone/telecom													0
7	Phone / telecom / cell phones / T1 / broadband													0
8	Equipment lease or rent (excl computer or software)													0
9	Computer hardware/software purch, uncapitalized													0
10	Furniture, fixtures, & other equip purch, uncapital'd													0
11	Maintenance, repairs, custodial, & security													0
12	Supplies, postage, freight, printing													0
13	Legal & prof services, incl ext audit, tax, consult													0
14	Travel expenses													0
15	Marketing, PR, & Outreach (excl. salaries)													0
16	Taxes (excluding income taxes) & Licensing													0
17	Insurance													0
18	Depreciation & amortiza ion													0
19	Subtotal	0	0	0	0	0	0	0	0	0	0	0	0	0
20	Other Expenses													0
21	**Contractor Admin Payments to Affiliated Parties**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
22	Is Line 20 "Other" > 10% of Line 19?	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	If Line 22 is "YES" in any month, provide breakdown of Other (at bottom of page)													
	from prior page (Page 4a):													
23	**Contractor Admin Payments to Unaffiliated Parties**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
24	**TOTAL ADMINISTRATION EXPENSES**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
25	*# of Enrollees (Members) - Total*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
26	**Administration Cost PMPM** (per Member per month)	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
27	**Administration Cost as % to Revenues**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
28	Total # of Transportation Trips	0	0	0	0	0	0	0	0	0	0	0	0	0
29	**Average Administration Cost per Trip**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
30	**Avg Admin Costs as a % of Operating Expenses**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**

Area to provide breakdown of line item 20, "Other," as may be required:

20		$0
		0
		0
		0
		0
		0
		0
		0
		0

Contractor name: **0**
Region: **0**
State Fiscal Year: **2015** Submission Type: Qtr 1
Submission Date: December 31, 2014
Accrual Date: November 30, 2014

State of Texas, Health & Human Services Commission
Medical Transportation Program - Managed Transportation Organization Contract
FINANCIAL STATISTICAL REPORT (FSR)
Contractor s self-reported data must be in compliance with the MTP Cost Principles.
Reporting is on an incurred basis and all numbers are subject to audit by HHSC or its designee.

printed: 8/17/2017

Version # **1.0**

Page 3c: Administrative Salaries by Department

		2014			2014	2015						2015		
	Incurred Months:	September	October	November	December	January	February	March	April	May	June	July	August	YTD
	Salaries, wages, benefits & bonuses, by functional Department													
	Salary Paid by Contractor Directly to Employees													
1	Call Center													$0
2	Transportation Coord. & Mgmt.													0
3	Facility Reps													0
4	FREW Audit, FREW Compliance, etc.													0
5	Claims Processing & Management													0
6	Fraud & Abuse control and management													0
7	Quality assurance / control / management													0
8	Customer Service													0
9	IT / Automation / PC Support / Web													0
10	Utilization Review													0
11	HR / Payroll / Training													0
12	Accounting & Finance / Taxes / Int Audit / Reportg													0
13	Marketing / PR / Outreach													0
14	Legal													0
15	Receptionist / Security / Custodial / Maintenance													0
16	CEO / COO / President / Exec Director / Gen Mgr													0
17	Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
18	Other	0	0	0	0	0	0	0	0	0	0	0	0	0
19	**Total Contractor Payments Directly to Employees**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
20	Is Line 18 "Other" > 10% of Line 17?	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	If tem 20 is "YES" in any month, provide breakdown of Other (at bottom of page)													
	Salary Billed to Contractor by Affiliated Party or Parent													
21	Call Center													$0
22	Transportation Coord. & Mgmt.													0
23	Facility Reps													0
24	FREW Audit, Compliance, etc.													0
25	Claims Processing & Management													0
26	Fraud & Abuse control and management													0
27	Quality assurance / control / management													0
28	Customer Service													0
29	IT / Automation / PC Support / Web													0
30	Utilization Review													0
31	HR / Payroll / Training													0
32	Accounting & Finance / Taxes / Int Audit / Reportg													0
33	Marketing / PR / Outreach													0
34	Legal													0
35	Receptionist / Security / Custodial / Maintenance													0
36	CEO / COO / President / Exec Director / Gen Mgr													0
37	Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
38	Other	0	0	0	0	0	0	0	0	0	0	0	0	0
39	**Total Salary Billed by Affiliated Party or Parent**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
40	Is Line 38 "Other" > 10% of Line 37?	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	If Line 38 is "YES" in any month, provide breakdown of Other (below)													
41	**Area to provide breakdowns of Lines 18 and/or 38, as may be required**													
18														0
														0
														0
38														0
														0
														0

Contractor name: **0**
Region: **0**
State Fiscal Year: **2015** Submission Type: Qtr 1
Submission Date: December 31, 2014
Accrual Date: November 30, 2014

State of Texas, Health & Human Services Commission
Medical Transportation Program - Managed Transportation Organization Contract
FINANCIAL STATISTICAL REPORT (FSR)
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Page 3c: Administrative Salaries by Department

	2014			2014	2015							2015	
Incurred Months:	September	October	November	December	January	February	March	April	May	June	July	August	YTD
													0

Contractor name: **0**
Region: **0**
State Fiscal Year: **2015** Submission Type: Qtr 1
Submission Date: December 31, 2014
Accrual Date: November 30, 2014

State of Texas, Health & Human Services Commission
Medical Transportation Program - Managed Transportation Organization Contract
FINANCIAL STATISTICAL REPORT (FSR)
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Page 4: Summary Income Statement

Note: Contractor may have incurred costs that are not allowable for inclusion in this HHSC report. See Certification tab, & HHSC s Cost Principles. Substantial interest & penalties can be assessed for mis-reporting.

	calendar year:	2014			2014	2015							2015	
	Incurred Months:	September	October	November	December	January	February	March	April	May	June	July	August	YTD
1	***Total # of Member-Months***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	*0*
	average # of members													**n/a**
	Contract Revenues:													
2	HHSC Capitation Premium Payments to MTO	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
3	Investment income & interest earned													0
4	Other contract-related revenue													0
5	**Total Revenues**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Allowable Contract Expenses:													
6	Client Svcs - Adults	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Client Svcs - Children	0	0	0	0	0	0	0	0	0	0	0	0	0
8	Client Svcs - Special Populations	0	0	0	0	0	0	0	0	0	0	0	0	0
9	Total Operating Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
10	Administrative Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0
11	**Total Allowable Expenses**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
12	**Net Income before Taxes**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	(as defined by HHSC)													
13	% Operating Expenses to Revenues	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
14	% Admin Expenses to Revenues	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
15	**% Pre-Tax Income to Revenues**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
16	Average Revenues per Member-Month	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
17	**MTO Total Costs per Member-Month**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
18	Average Income per Member-Month	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
19	MTO Op. Costs per Mbr-Mo - Urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
20	MTO Op. Costs per Mbr-Mo - Rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
21	**Total # of Transportation Trips**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
22	Tot Cost to HHSC - Avg per Trip (incls Admin)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
23	**Tot Costs to MTO - Avg per Trip** (incls Admin)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
24	# Trips per thousand Members per Month	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
25	**% Rural** (by # of Enrollees)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
26	Avg **# Miles per** ground **trip** (excl bus)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	**#DIV/0**
27	**- Urban miles per trip**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
28	**- Rural miles per trip**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
	Avg Op **Cost per mile** (excls. Admin Expenses):													
29	- ALL ground trips (excl mass transit bus)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	**#DIV/0**
30	- Demand Response, Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
31	- Demand Response, Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
32	% of aggr DR costs that are Affiliate	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	**#DIV/0**
33	Accrual $ included in Op. Exp. above	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
34	Accrual % to total Op. Exp.	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
35	Liquidated Damages													$0

Note: in these pages, "per Member-Month" = PMEPM = PMPM.

"Client Services Expenses" (also referred to as "Client Services Operating Costs" or "Operating Expenses") refers herein to amounts paid directly to third parties by the MTO for the purchase of specific transportation, meals, and lodging for HHSC beneficiaries. These Client Services Operating Costs do not include any of the MTO's administrative or overhead expenses.

Unless specifically indicated otherwise, costs are to be reported in the monthly column corresponding to when the service was provided, as opposed to the timing being determined by when the bill was received, or when the amount was paid.
Accruals entered for a given month should be updated in subsequent reports, as estimates turn into actuals. There must be no accruals remaining for the final yearly report.

DATA CERTIFICATION FORM

printed: 8/17/2017

Version # 1.0

1. **0**
Contractor Name (Name of legal entity, and any dba utilized)

2. **HHSC Financial Statistical Report (FSR) for Managed Transportation Organization (MTO)**
Document Name

3. *Region:* **0**

4. *Date of Submission:* **December 31, 2014**

5. **2015 Qtr 1**
State Fiscal Year, & Quarter, covered

The Managed Transportation Organization, herein called "MTO" or "Contractor," is hereby authorized to submit encounter data to the Texas Health and Human Services Commission (HHSC) for services rendered by the undersigned MTO, in machine-readable form, as specified by HHSC. Contractor is also required to submit data in the attached Financial Statistical Report (FSR). The FSR is an HHSC-defined form, and must be filled-out by the Contractor according to contractual definitions.

By my signature below, I certify that the data and/or documents so recorded and submitted as input data or information, based on my best knowledge, information, and belief: are in compliance with Subpart H of the Balanced Budget Act Certification requirements; are complete, accurate, and truthful; and are in accordance with all Federal and State laws, regulations, policies, and the HHSC Contract now in effect. Contractor further certifies that it will retain and preserve all original documents as required by law, submit all or any part of the same, or permit access to same for audit purposes, as required by HHSC or any agency of the federal government, or their representative(s). Document access and retention extends to source documents needed to verify any costs billed to or assessed to the Contractor by the Contractor's parent or any other Affiliate; such source documents may include parts of the books and records of the parent or other Affiliate.

I understand that many types of costs recognized as legitimate by the IRS and by Generally Acceptable Accounting Principles (GAAP) are unallowable for inclusion in HHSC's Financial Statistical Report (FSR); details are in HHSC's Cost Principles. Such costs are not allowed for inclusion either directly, or indirectly via blended amounts in Affiliate assessments, etc. I certify by my signature below that this data submission excludes these unallowed costs, to the best of my knowledge.

I understand that some of the common types of costs that are unallowed to be reported in the FSR include interest expense; income taxes (federal, state, or local), including state franchise taxes; bad debt expense; contributions and donations; lobbying; royalty fees and franchise fees; HHSC Liquidated Damages and Experience Rebates; markups, add-ons, margin, or profits by Affiliates; entertainment; alcoholic beverages; fines, penalties, damages, and settlements; bond issuance cost amortization, and bond discounts; provision for contingent reserves; cost of capital; defense or prosecution of criminal proceedings, civil proceedings, and claims; investment management costs; loss on disposition of property; costs of memberships, dues and expenses associated with country club and fraternal organizations; political contributions; proposal preparation costs; and, airfare costs in excess of standard coach class.

6. _____
Printed Name and Title of CEO, CFO, or equivalent (no delegates)

7. 0
On behalf of (legal name of Contractor)

8. _____
Legal Signature of Officer named above

9. _____
Date signed

This sheet may be used by Contractor for any purpose; it is not required.

	HHSC Medical Transportation Program	Version 1.0
	Managed Tranportation Organization (MTO)	Effective Date **Sept 16, 2013**
	Financial Statistical Report (FSR)	

DRAFT

DOCUMENT HISTORY LOG			
STATUS	**DOCUMENT REVISION**	**EFFECTIVE DATE**	**DESCRIPTION**
Baseline	**1.0**	September 16, 2013	Initial version of the HHSC Medicaid non-emergency medical transportation Managed Transportation Program (MTP) Managed Transportation Organization (MTO) Financial Statistical Report (FSR). This document is required by contract to be completed and submitted to HHSC by certain contracted vendors (MTOs) on a specified schedule, and according to HHSC's Cost Principles.

Contractor name: **0**
Region: **0**
State Fiscal Year: **2015** Submission Type: Qtr 1
Submission Date: December 31, 2014
Accrual Date: November 30, 2014

State of Texas, Health & Human Services Commission
Medical Transportation Program - Managed Transportation Organization Contract
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printed: 8/17/2017
Version # 1.0

Page 7a: Summary by Risk Group

		2014			2014	2015							2015	
	Incurred Months:	September	October	November	December	January	February	March	April	May	June	July	August	**YTD**
	# of Enrollees:													
1	Adults, urban	0	0	0	0	0	0	0	0	0	0	0	0	0
2	Adults, rural	0	0	0	0	0	0	0	0	0	0	0	0	0
3	Children, urban	0	0	0	0	0	0	0	0	0	0	0	0	0
4	Children, rural	0	0	0	0	0	0	0	0	0	0	0	0	0
5	Spec Pop, urban	0	0	0	0	0	0	0	0	0	0	0	0	0
6	Spec Pop, rural	0	0	0	0	0	0	0	0	0	0	0	0	0
7	total	0	0	0	0	0	0	0	0	0	0	0	0	0
	Revenues:													
8	Adults, urban	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
9	Adults, rural	0	0	0	0	0	0	0	0	0	0	0	0	0
10	Children, urban	0	0	0	0	0	0	0	0	0	0	0	0	0
11	Children, rural	0	0	0	0	0	0	0	0	0	0	0	0	0
12	Spec Pop, urban	0	0	0	0	0	0	0	0	0	0	0	0	0
13	Spec Pop, rural	0	0	0	0	0	0	0	0	0	0	0	0	0
14	total	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
	Client Svcs Op Costs:													
15	Adults, urban	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
16	Adults, rural	0	0	0	0	0	0	0	0	0	0	0	0	0
17	Children, urban	0	0	0	0	0	0	0	0	0	0	0	0	0
18	Children, rural	0	0	0	0	0	0	0	0	0	0	0	0	0
19	Spec Pop, urban	0	0	0	0	0	0	0	0	0	0	0	0	0
20	Spec Pop, rural	0	0	0	0	0	0	0	0	0	0	0	0	0
21	total	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
	Admin Expenses:													
22	Adults, urban	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
23	Adults, rural	0	0	0	0	0	0	0	0	0	0	0	0	0
24	Children, urban	0	0	0	0	0	0	0	0	0	0	0	0	0
25	Children, rural	0	0	0	0	0	0	0	0	0	0	0	0	0
26	Spec Pop, urban	0	0	0	0	0	0	0	0	0	0	0	0	0
27	Spec Pop, rural	0	0	0	0	0	0	0	0	0	0	0	0	0
28	total	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
	Aggregate pre-tax income $:													
29	Adults, urban	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
30	Adults, rural	0	0	0	0	0	0	0	0	0	0	0	0	0
31	Children, urban	0	0	0	0	0	0	0	0	0	0	0	0	0
32	Children, rural	0	0	0	0	0	0	0	0	0	0	0	0	0
33	Spec Pop, urban	0	0	0	0	0	0	0	0	0	0	0	0	0
34	Spec Pop, rural	0	0	0	0	0	0	0	0	0	0	0	0	0
35	total	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
	Income % to revenues:													
36	Adults, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
37	Adults, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
38	Children, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
39	Children, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
40	Spec Pop, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
41	Spec Pop, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
42	total	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**

Contractor name: **0**
Region: **0**
State Fiscal Year: **2015** Submission Type: Qtr 1
Submission Date: December 31, 2014
Accrual Date: November 30, 2014

State of Texas, HHSC
Managed Transportation Program
FINANCIAL STATISTICAL REPORT (FSR)
Contractor s self-reported data must be in compliance with the MTP Cost Principles.

printed: 8/17/2017

Version # **1.0**

Page 7b: Summary by Risk Group (continued)

		2014			2014	2015						2015		
	Incurred Months:	Sept	Oct	Nov	Dec	January	February	March	April	May	June	July	August	**YTD**
	Premium $-PMPM:													
1	Adults, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2	Adults, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
3	Children, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
4	Children, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
5	Spec Pop, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
6	Spec Pop, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
7	total	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
	Client Svcs $-PMPM:													
8	Adults, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
9	Adults, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
10	Children, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
11	Children, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
12	Spec Pop, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
13	Spec Pop, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
14	total	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
	Admin Exp $-PMPM:													
15	Adults, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
16	Adults, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
17	Children, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
18	Children, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
19	Spec Pop, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
20	Spec Pop, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
21	total	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
	MTO total cost $-PMPM:													
22	Adults, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
23	Adults, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
24	Children, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
25	Children, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
26	Spec Pop, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
27	Spec Pop, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
28	total	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
	Income $-PMPM:													
29	Adults, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
30	Adults, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
31	Children, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
32	Children, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
33	Spec Pop, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
34	Spec Pop, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
35	total	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
	# of trips per thousand Enrollees per Month:													
36	Adults, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
37	Adults, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
38	Children, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
39	Children, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
40	Spec Pop, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
41	Spec Pop, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
42	total	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	# of miles per trip *(excls bus & air)* **:**													
43	Adults, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
44	Adults, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
45	Children, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
46	Children, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
47	Spec Pop, urban	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
48	Spec Pop, rural	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
49	total	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	**#DIV/0!**
50	**urban** subtotal	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
51	**rural** subtotal	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**

0

Region: **0**

Year-to-Date Overview

SFY: **2015** ***0*** *months*

submitted: 12/31/2014

# of months: **0**

risk group:	ADULTS		CHILDREN		Special Populations		Urban	Rural	
	Urban	Rural	Urban	Rural	Urban	Rural	subtotal	subtotal	**total**
Avg # of Members	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	**n/a**
% to total	*#DIV/0!*	*#DIV/0!*	*#DIV/0!*	*#DIV/0!*	*#DIV/0!*	*#DIV/0!*	*#DIV/0!*	*#DIV/0!*	*#DIV/0!*
# of Member-Months	0	0	0	0	0	0	0	0	0
avg cap rate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
cap premiums	$0	$0	$0	$0	$0	$0	$0	$0	$0
total revenues	$0	$0	$0	$0	$0	$0	$0	$0	$0
client svcs op expenses:									% of op exp
- ground trips	$0	$0	$0	$0	$0	$0	$0	$0	$0 n/a
- airfare	0	0	0	0	0	0	0	0	$0 n/a
- client meals & lodging	0	0	0	0	0	0	0	0	$0 n/a
- accruals	0	0	0	0	0	0	0	0	$0 n/a
- total op. expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0 0%
total admin overhead exp	0	0	0	0	0	0	0	0	0 **n/a**
total MTO costs	$0	$0	$0	$0	$0	$0	$0	$0	$0
% to total MTO costs	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*0%*
pre-tax income	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
income %	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	***n/a***
# of trips	0	0	0	0	0	0	0	0	**0**
# trips per 1,000 mbrs/mo	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**
MTO cost per trip:									
- client svcs op expenses	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
- admin OH expenses	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
- total MTO expense / trip	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**n/a**
HHSC cost / trip	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
MTO cost PMPM:									
- client svcs op expenses	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
- admin OH expenses	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
- total MTO expense PMPM	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**n/a**
HHSC cost PMPM	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
MTO cost details (excluding Admin):									
$ per Demand Resp trip:									% of TRIPS
- Non-Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	#DIV/0! n/a
- Affiliate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	#DIV/0! n/a
$ per Mileage trip	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	#DIV/0! n/a
$ per Mass Trans bus tr	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	#DIV/0! n/a
$ per Air fare	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	#DIV/0! n/a
$ per night's lodging	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	#DIV/0!
$ per meal	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	#DIV/0!
									% of op exp
Demand Resp - tot aggr costs	$0	$0	$0	$0	$0	$0	$0	$0	$0 n/a
Mileage - tot aggr costs	0	0	0	0	0	0	0	0	0 n/a
mass trans bus - tot aggr costs	0	0	0	0	0	0	0	0	0 n/a
DR - # miles per trip	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Mileage - # miles per trip	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
DR - $ cost per mile	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Mileage - $ cost per mile	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
pre-payments / cash advances	$0	$0	$0	$0	$0	$0	$0	$0	$0
% to op costs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

0 Region: **0**

Admin Expenses: YTD Summary # of months: **0**

submitted: 12/31/2014 SFY: 2015

	direct	affiliate	total	
avg. # of beneficiaries under management			*n/a*	
# of trips, YTD			*0*	
# of FTEs	n/a	n/a	**0**	
# of sq. ft.	n/a	n/a	0	
Admin costs (YTD):				% of OpEx
salaries, benefits, & bonuses (see detail below)	$0	$0	$0	n/a
rent & utilities	0	0	0	n/a
Phone / telecom / cell phones / T1 / broadband	0	0	0	n/a
Computer hardware/software purch, uncapitalized	0	0	0	n/a
Depreciation & amortization	0	0	0	n/a
all other Admin	0	0	0	n/a
Total Admin	$0	$0	**$0**	**n/a**
Admin per Member-Month			**n/a**	
Admin per Trip			**n/a**	
stats:				
avg. Salary, ben & bonus per FTE (annualized)	#DIV/0!	#DIV/0!	**#DIV/0!**	
rent & utilities per sq. ft. (per year)	#DIV/0!	#DIV/0!	#DIV/0!	
avg # of sq ft per FTE	#VALUE!	#VALUE!	n/a	
# of beneficiaries managed per FRB FTE			**ERROR**	
# of trips managed per FRB FTE (avg per month)			**#DIV/0!**	
bonuses	$0	$0	$0	n/a
bonuses as % of salaries & ben	n/a	n/a	n/a	
bonuses as % of rptd pre-tax income			n/a	
reference: pre-tax income as % of revenues			n/a	

Salaries detail, by functional department (YTD):				% of OpEx
Customer Service	$0	$0	$0	**n/a**
Transportation Coord. & Mgmt.	0	0	0	**n/a**
Quality assurance / control / management	0	0	0	**n/a**
Call Center	0	0	0	**n/a**
CEO / COO / President / Exec Director / Gen Mgr	0	0	0	**n/a**
Claims Processing & Management	0	0	0	**n/a**
Facility Reps	0	0	0	**n/a**
FREW Audit, FREW Compliance, etc.	0	0	0	**n/a**
HR / Payroll / Training	0	0	0	n/a
Receptionist / Security / Custodial / Maintenance	0	0	0	n/a
Utilization Review	0	0	0	n/a
Marketing / PR / Outreach	0	0	0	n/a
IT / Automation / PC Support / Web	0	0	0	n/a
Fraud & Abuse control and management	0	0	0	n/a
Accounting & Finance / Taxes / Int Audit / Reportg	0	0	0	n/a
Legal	0	0	0	n/a
Other	0	0	0	n/a
Total Salaries, benefits, wages, & bonuses	$0	$0	**$0**	n/a

AGREEMENT BETWEEN THE
TEXAS HEALTH AND HUMAN SERVICES COMMISSION
AND
LOGISTICARE SOLUTIONS, LLC

EXHIBIT K

Revised Performance Standards and Liquidated Damages (modification of RFP attachment S)

Attachment K
Performance Standarc

Exhibit L Key
Performance Requin

Nonemergency Medical Transportation
Managed Transportation Organizations (MTOs)
Key Performance Requirements
RFP No. 529-15-0002

Performance measures are applicable at all times and may be monitored accordingly. Accelerated monitoring may occur as needed. Performance standard will be applied to regular monitoring visits or any other follow up or occurrence as deemed necessary by HHSC. Performance Measures may not be subject to more than one Performance Standard and associated Liquidated Damage assessment.

Definitions

"Performance Standard" refers to the specific, desired or required outcome or result of the MTO's performance

"Performance Measure" refers to the specific number, amount, percentage or duration of the activity or deliverable described in the Performance Standard

"Monitoring Period" refers to the specific period of time during which the MTO's performance will be monitored for compliance with the Performance Standard and subject to potential remedies under the contract

"Cure Period" refers to the time specified as a grace period in this document for each Performance Measure during which the MTO may perform the required service or supply the required deliverable

"Base Liquidated Damage Value" is the dollar amount HHSC will apply to each unit or instance of noncompliance with a Performance Measure

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
MTO 1	Section 1.6.2	Service Delivery The MTO must arrange, coordinate, schedule, and provide transportation services to meet the needs of the client	98% of all services must be arranged, coordinated, scheduled, dispatched and provided to meet the clients' needs	Quarterly unless accelerated by HHSC	0 calendar days	$1,500 per percentage point below 98% when the service is not delivered.
MTO 2	Section 2.3.10.11	The monthly average maximum wait (before answered by a live person) will not exceed 900 seconds, inclusive of all IVR time, for calls other than from or on behalf of a child birth through 20, with Medicaid. (see § 2.35.9 for calculation	Monthly average maximum wait of 900 seconds, or less, for calls other than from or on behalf of a child birth through 20 with Medicaid.	Monthly	n/a	$2,500 for the first month in which the average maximum wait times fail to meet the monthly standard specified related to the client toll free line for transportation services, for those calls determined to be from other than or on behalf of a child

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		methodology). This measure is calculated as follows: 1. The MTO must track the length of the call that had the longest wait prior to speaking to a live person, each day. 2. The wait time includes all time spent in the IVR (or auto-attendant) as well as the time waiting in queue. 3. The length of each daily call with the longest wait, prior to speaking to a live person for the month will be combined and divided by the total number of business days in the month, 4. The resulting number must not exceed 300 seconds.				birth through 20 with Medicaid. Liquidated damages will continually increase by $1,250 for each subsequent, consecutive month that non-compliance continues.
MTO 3	Section 2.3.10.11	The average monthly wait to speak to a live person after the IVR message and conclusion of user selection of menu items, for calls from callers other than from or on behalf of a child birth through 20 with Medicaid. This measure is derived by dividing the total monthly time in queue for these calls	Monthly average speed of answer to a live agent will not exceed 180 seconds, for calls from callers other than from or on behalf of a child birth through 20 with Medicaid.	Monthly	n/a	$2,500 for the first month in which the average monthly wait to speak to a live person fails to meet the monthly standard specified herein, related to the client toll free line for transportation services, for those calls determined to be from callers other than from or on behalf of a child birth through 20 with Medicaid.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		(placed by callers other than from or on behalf of a child birth through 20, with Medicaid), by the number of answered calls for the month (placed by callers other than from or on behalf of a child birth through 20, with Medicaid), during the hours specified in §2.3.10.1.				Liquidated damages will continually increase by $1,250 for each subsequent, consecutive month that non-compliance continues.
MTO 4	Section 2.3.10.11	The number of calls that abandon, after conclusion of any IVR (or auto-attendant) selections, determined to be placed by callers other than from or on behalf of a child birth through 20, with Medicaid, during hours referenced in §2.3.10.1. This measure is determined as follows: The percentage of calls received from callers other than from or on behalf of a child birth through 20, with Medicaid during each month that are abandoned, after conclusion of any IVR (or auto-attendant) selections, determined to be placed by callers from or on behalf of a child birth through 20, with Medicaid, during hours referenced in §2.3.10.1. The	Monthly abandon rate will not exceed 12%, for calls from callers other than from or on behalf of a child birth through 20 with Medicaid.	Monthly	n/a	$2,500 for the first month in which the MTO fails to meet the monthly standard specified in §2.3.10.11 related to the client toll free line for transportation services, for those calls determined to be from callers other than from or on behalf of a child birth through 20 with Medicaid. Liquidated damages will continually increase by $1,250 for each subsequent, consecutive month that non-compliance continues.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		monthly total for this measure is divided into the monthly total calls received, after conclusion of any IVR (or auto-attendant) selections, determined to be placed by callers from or on behalf of a child birth through 20, with Medicaid, during hours referenced in §2.3.10.1.				
MTO 5	Section 2.3.11	The MTO's monthly report will include individual exam scores on new materials for MTO staff who answered calls for the prior month. "New materials" shall include training for new staff or training of existing staff on new or updated materials. The MTO's monthly report will include individual exam scores on retraining for MTO staff who answered calls for the prior month. "Re-training" shall include those staff, that call monitoring indicates a need for re-training. MTO staff who do not achieve the minimum required score for each exam on new materials and/or	For staff answering calls from MTP eligible clients, each individual must achieve a minimum score of 85% or better on all new material exams or re-training exams.	Each month in which staff answers calls from MTP eligible clients.	n/a	$250 for each occurrence. "Occurrence" is defined here as each new material exam score or re-training exam score below 85% (the most recent exam on the topic) per staff who answered calls from MTP eligible clients during the month. It is not required that all MTO staff meets the 85% on the first try. Individuals failing to meet or exceed that minimum must not answer calls from MTP eligible clients until they are re-tested and able to achieve a score of 85% or better. Exam questions for staff being re-tested must be sufficiently different, to discourage memorization of the previous exam answers.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		retraining must not answer calls until the required scores are achieved, via initial test or re-test. MTO must submit and certify the summary testing and/or re-testing report to HHSC by the 2nd business day of the month following any month in which MTO staff answers calls. The monthly report must be submitted in a media and format approved by HHSC.				Liquidated damages will continually increase by $125 (per exam, per staff) for each subsequent, consecutive month that non-compliance continues, for that particular MTO staff. Example: the MTO new hire training are comprised of 10 exams. MTO Agent A scores 85% or better on 8 of those exams and 70% on the remaining two exams. If MTO Agent A answers calls from MTP eligible clients during the month, liquidated damages of $500 are due (two exam scores below 85%). However, if MTO Agent A re-takes the two exams in question and eventually achieves 85% or greater on both of them before answering calls from MTP eligible clients, no liquidated damages are due for this measure for Agent A. "Re-test" is defined as a subsequent attempt to achieve the required score by an individual, on a test, per topic. Note that re-test is different from re-training

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						(see definition of re-training below). The monthly summary testing report will indicate the MTO staff who answered calls from MTP eligible clients for the prior month and the most recent individual exam scores on new materials for these staff, for all topics. The submission of false or inaccurate information in reports will result in assessment of a liquidated damage of $10,000 and will entitle HHSC to terminate the agreement. HHSC will report suspected fraudulent reporting to appropriate enforcement authorities.
MTO 6	Section 2.3.11; 2.35.4;	MTP call center customer service measures (applies to all callers): • • Telephone staff must greet callers and identify themselves by first name and identification number when answering.	Maintain a monthly average score of 85% for MTP call center customer service measures, for all MTP call center calls monitored, as indicated on the MTP call center summary quality activity report.	Monthly	n/a	$1,250 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $625 for each subsequent, consecutive month that non-compliance continues. "Occurrence" is defined here as month when the average score of all MTP call center customer service standards

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						(as indicated by call monitoring sessions) drops below 85%. Example: The section(s) of MTO monitoring form for MTP call center calls that addresses the MTP call center customer service measures will yield a score, that when averaged across all MTP call center calls monitored for the month, will meet or exceed 85%, in order to be compliant. Note: Depending on the design of the MTO monitoring form, this standard may be broken out into separate standards, or may require other modification, which will be addressed during negotiations.
MTO 7	Section 2.3.12	Submit monitoring forms and monitored calls monthly pertaining to MTP eligible clients. Reports must be submitted in a media and format approved by HHSC.	Submit monitoring forms monthly pertaining to MTP eligible clients, as specified.	Monthly	n/a	$250 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $125 for each subsequent, consecutive week that non-compliance continues. “Occurrence” is defined here as each week in which the

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						MTO does not submit the monitoring forms and monitored calls as required.
MTO 8	Section 2.3.12	Monitor and evaluate staff performance for calls from MTP eligible clients to the client toll-free line for transportation services. Calls must be submitted in a media and format approved by HHSC.	Monitor and evaluate 2% of calls from MTP eligible clients, as indicated on the summary quality activity report.	Monthly	n/a	$1,250 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $625 for each subsequent, consecutive month that non-compliance continues. "Occurrence" is defined here as each month were the MTO does not monitor and evaluate a minimum of 2% of MTP eligible client calls on staff who answer calls via the client toll-free line for transportation services, as indicated on the summary quality activity report. Note: Rounding is limited to the nearest hundredth of one percent; at that point a number greater or equal to 2% must be the result in order to be considered compliant. The submission of false or inaccurate information in reports will result in assessment of a liquidated damage of $10,000 and

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						entitle HHSC to terminate the agreement. HHSC will report suspected fraudulent reporting to appropriate enforcement authorities.
MTO 9	Section 2.3.12	Submit a quality activity report monthly to HHSC pertaining to MTP eligible clients. Reports must be submitted in a media and format approved by HHSC.	Submit a quality activity report monthly pertaining to MTP eligible clients.	Monthly	n/a	$375 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $188 for each subsequent, consecutive month that non-compliance continues. "Occurrence" is defined here as each instance where the report is submitted past the specified due date. The submission of false or inaccurate information in reports will result in assessment of a liquidated damage of $10,000 and entitle HHSC to terminate the agreement. HHSC will report suspected fraudulent reporting to appropriate enforcement authorities.
MTO 10	Section 2.3.12	This standard applies from the point at which the call reaches the toll free number platform to the point at which the call is answered by a live operator. It applies to all	Monthly percentage of blocked or failed calls at point where MTO picks up call from HHSC (for client toll free line for transportation services,	Monthly	n/a	$2,500 for the first month in which the MTO fails to meet the monthly standard specified in §2.3.12 related to the client toll free line for transportation services, for

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		calls determined to be placed by callers other than from or on behalf of a child birth through 20, with Medicaid during the hours referenced in §2.3.10.1. All call attempts during this time (determined to be placed by callers other than from or on behalf of a child birth through 20 with Medicaid) are divided into the number of attempts that received a busy signal, network error or any other type of response, other than being passed to a live operator (determined to be placed by callers, other than from or on behalf of a child birth through 20, with Medicaid).	for calls other than from or on behalf of a child birth through 20, with Medicaid), will not exceed 2%.			those calls determined to be from callers other than from or on behalf of a child birth through 20 with Medicaid. Liquidated damages will continually increase by $1,250 for each subsequent, consecutive month that non-compliance continues.
MTO 11	Section 2.4	The MTO will maintain and answer a toll-free number for clients to request a return ride, if their ride is more than 15 minutes late, and for non-client issues. Calls to this toll-free number must be answered by live operators continuously as specified in Section 2.3.10.1. This number must be different from the client toll-free number for transportation services.	No failure to telecommunications related hardware and software, and no failure of staff to answer client calls to this toll free line during the hours specified.	Per occurrence	n/a	$1,000 per failure to meet the requirements for all equipment, software, trunks, routing, etc. that impact call processing or handling for all callers to the Toll Free Client Line for transportation services. Liquidated damages will continually increase by $500 for each subsequent thirty minute period, after the initial five minutes of the outage until operations are

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						fully restored. Liquidated damages will accrue only during the line's operational (business) hours. Any measureable amount of time over a minute (i.e., a second) will advance this determination into the next minute (e.g., 5 minutes and 2 seconds will be treated as 6 minutes). Example: At 10:00 AM MTO staff spills coffee on a critical server which causes this toll-free line to go down (with no redundant systems in place). If this toll-free line is operational and staff are answering calls within: • 5 minutes, the liquidated damages for this instance are $1,000. • 6 - 35 minutes, the liquidated damages for this instance are $1,500. • 36 - 65 minutes, the liquidated damages for this instance are $2,000. • 66 - 95 minutes, the liquidated damages for this instance are $2,500. • 96 - 105 minutes, the liquidated damages for this instance are $3,000, etc.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
MTO 12	Section 2.5.2	Management The MTO will assure that key personnel staff who have authority to act on a request from the HHSC designated staff, a complaint, or any other matter relating to the performance of the services is available at minimum during MTO Hours of Operation. MTO key personnel staff will respond within 1 hour of the HHSC inquiry.	100% of the MTO's Hours of Operation will be staffed by key personnel to respond to HHSC inquiries within 1 hour.	Continuous Monitoring	0 calendar days	$500 for each hour that MTO key personnel staff did not respond within 1 hour.
MTO 13	Section 2.5.2	Management The MTO will maintain the agreed upon staffing of key personnel.	100% of the MTO's key personnel be staffed as agreed upon by HHSC and the MTO (per RFP section 2.10.1, key personnel must be replaced within 90 days after vacancy of position).	Continuous Monitoring	0 calendar days	$1,000 for each MTO business day that the MTO did not meet agreed upon qualified staffing requirements of key personnel or failed to receive HHSC's approval prior to hiring.
MTO 14	Section 2.5.3	MTO must notify HHSC in writing at least five (5) business days of a position becoming vacant.	Each calendar day after due date	Ongoing		$100 per day
MTO 15	Section 2.7.2	Service Assessment The MTO must adhere to and utilize the HHSC approved policy in determining the appropriate client transportation services.	100% of all services must be authorized by MTO and determined to meet the clients' needs utilizing the HHSC approved policy.	As requested by HHSC	0 calendar days	$500 per authorization of service where the MTO failed to utilize the HHSC approved policy to determine the appropriate client transportation service, not applicable to actual

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						service delivery.
MTO 16	Section 2.7.6	Service Complaints The MTO will respond to client service delivery complaints within 5 days, Ombudsman complaints within 3 days, Legislator's office complaints within 24 hours.	98% of all complaints in a calendar month will receive a response from the MTO within the performance standard timeframe.	Monthly unless accelerated by HHSC	0 calendar days	$1,000 each percentage point below 98%.
MTO 17	Section 2.7.7	Failure of MTO to show up and adequately represent HHSC at all fair hearings.	Each occurrence	Ongoing		$5,000 per occurrence
MTO 18	Section 2.10.1	Demand Response Services The MTO must maintain a current vehicle and driver roster used to provide transportation to program clients.	100% of vehicles and drivers used in the service delivery to clients will be maintained on a vehicle and driver roster. This Performance Standard excludes drivers or vehicles that HHSC and the MTO agree are not required to be included on the driver or vehicle roster, such as public transit.	Monthly unless accelerated by HHSC	3 calendar days	$2,500 for each incident where the MTO used a vehicle or driver that was not included on the roster.
MTO 19	Section 2.11.1	Customer Service Surveys The MTO must maintain a 95% client satisfaction survey result as determined by the survey conducted by the independent research organization. Corrective action plans must be submitted to HHSC if less	95% of all client surveys will indicate satisfaction with transportation services provided or arranged by MTO or its Performing Providers.	Quarterly	0 calendar days	$2,500 for each quarter that client surveys did not meet the 95% threshold.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		than 95% client satisfaction.				
MTO 20	Section 2.11.1	Customer Service Surveys The MTO must contract with an independent research organization to conduct quarterly client and medical service provider satisfaction surveys.	100% of all client surveys will be performed by an independent contractor	Quarterly	0 calendar days	$8,000 for each quarter that client surveys are not conducted by an independent organization.
MTO 21	Section 2.11.1	Customer Service Surveys The MTO must submit client survey results by the contract required timeframes.	100% of client survey results will be submitted by the timeframe specified in the Reports Table.	Quarterly	0 calendar days	$5,000 for each quarter that client surveys did not meet the contract required timeframe.
MTO 22	Section 2.12.2	Failure to comply with a request from HHSC to provide proof of insurance documentation	Each occurrence	Ongoing	0 calendar days	$500 per day
MTO 23	Section 2.16 - Applicable Laws	Compliance with Laws The MTO must comply with the requirements of the laws applicable to the performance of the contract which include certain: a. state and federal regulations b. state Medicaid rules and regulations c. state regulations regarding transportation services d. Texas Administrative Code e. Corrective Action Orders and the Consent Decree *Frew* v Janek	100% compliance with Applicable Laws.	Continuous Monitoring by HHSC staff	0 calendar days	$5,000 a day when a MTO continues non-compliant actions after notification by HHSC that it is out of compliance with applicable laws.
MTO 24	Section: 2.10.2	Client Safety	100% of all persons	Continuously	0 calendar	$10,000 per accident when

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
	2.18.2; 2.18.4; 2.21; 2.22.2; 2.35.3	MTO must prepare a training plan, training materials and manuals for HHSC approval upon readiness review.	responsible for transporting clients must comply with all client safety procedures 100% of the time.		days	client injuries occurred due to failure to follow procedures in HHSC approved plans, materials and manuals. MTO will also be placed on automatic Corrective Action. Client injuries means an accident or incident where the client was injured and required medical attention or was assaulted or sexually harassed.
MTO 25	Section 2.15; 2.18.2; 2.18.3; 2.18.4; 2.22.2.4	<u>Required MTO Plans and Manuals</u> The MTO will adhere to the following HHSC approved plans and manuals: Inclement Weather Plan; Business Continuity and Disaster Recovery Plan; Performing Provider NEMT Manual; Operating Procedures Manual; Implementation Work Plan; Quality Assurance Plan Transition Plan	100% adherence to HHSC approved plans and manuals	Continuous Monitoring	0 calendar days	$1,500 per day for non-compliance for each plan.
MTO 26	Section 2.18.1	<u>Performing Provider Monitoring</u> The MTO will submit timely and complete Performing Provider monitoring reports.	100% complete monthly reports are submitted to HHSC by the required deadlines	Monthly unless accelerated or requested by HHSC	3 business days following the due date	$500 per report for each business day the report is not timely and complete (after Cure Period). A complete report contains an accurate response to each item required in the report.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
MTO 27	Section 2.18.1	Performing Provider Management The MTO must maintain documentation for 100% of its subcontracts, records specified in the Performing Provider NEMT Manual, agreements, Business Associate Agreements when applicable, required insurance coverage and enrollment information for Performing Providers listed on the MTO approved Performing Providers list at the Texas headquarters.	100% of Performing Provider records specified in the subcontract or Performing Provider NEMT Manual, agreements, Business Associate Agreements when applicable, and enrollment information for Performing Providers listed on MTO approved Performing Provider list must be at the MTO's Texas headquarters.	Continuous Monitoring	5 calendar days	$1,000 per occurrence when performance measure is not met. "Occurrence" means an agreement, record specified in the Performing Provider or NEMT Manual or enrollment information that is not on file at the MTO's Texas headquarters following the cure period.
MTO 28	Section 2.18.1	Performing Provider Monitoring The MTO will monitor all Performing Providers in accordance with all contract requirements, the Performing Provider NEMT Manual, and the approved Performing Provider Monitoring Plan. The MTO must meet oversight and monitoring requirements of all Performing Providers according to the contract requirements and approved Performing Provider Monitoring Plan.	100% of all Performing Providers are monitored according to contract requirements, the approved Performing Provider Monitoring Plan, and the Performing Provider NEMT Manual.	Continuous Monitoring	0 calendar days	$750 per requirement, per Performing Provider, per monitoring period for each monitoring performance measure not met. Supporting documentation will be required as proof that monitoring activities were performed.
MTO 29	Section 2.18.1; UTC 1.4.1.	Performing Provider Monitoring The MTO must submit	100% of all corrective action plans are submitted to HHSC by approved	Continuous Monitoring by HHSC	3 business days	$1,000 per occurrence when performance measure is not met. Occurrence means a

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		corrective action plans (CAP) by required timeframes.	timeframes or with extensions approved by HHSC			corrective action plan that is not submitted on time.
MTO 30	Section 2.18.1; UTC 1.4.1.	Performing Provider Monitoring The MTO must implement all items noted in the corrective action plan by required timeframes	100% of all items noted in HHSC approved corrective action plan must be implemented by the required timeframes	Continuous Monitoring by HHSC	0 calendar days	$1,000 per day for each item noted in corrective action plan that the MTO did not implement by timeframe required in CAP.
MTO 31	Section 2.18.1	Demand Response Services The MTO must ensure that a reliable fleet of vehicles, including ADA compliant vehicles, that meet federal, state and local ordinances, including insurance requirements are used to transport clients safely.	100% of vehicles providing services must meet performance standard requirements.	Quarterly unless accelerated by HHSC	3 calendar days	$1,000 for each vehicle when it does not meet the performance standard requirements at the time the vehicle was used to transport the client.
MTO 32	Section 2.9.4 and 2.18.1	Demand Response Services The MTO must ensure that drivers adhere to requirements in the HHSC approved Performing Provider NEMT Manual. Driver records must be kept at the Texas headquarter office and available for inspection.	100% of drivers will meet the requirements in the HHSC approved Performing Provider NEMT manual as documented by records retained by the MTO and available for inspection.	Continuous Monitoring by HHSC staff	3 calendar days	$1,000 for each driver that does not meet the requirements in HHSC approved Performing Provider NEMT manual as evidenced by records available for inspection in MTO's driver files or as noted during monitoring activities. $2,000 for unlicensed drivers or for the use of a driver prior to completing contract requirements and properly documenting criminal background checks

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						annually. $2,000 for any individual who provides services under the contract that has an impermissible criminal conviction.
MTO 33	Section 2.18.1	Demand Response Services The MTO must ensure that records of operating equipment for each vehicle used to provide client transportation are maintained at its Texas headquarter office for inspection.	100% of contract required vehicle documentation will be on site and available for inspection.	Quarterly unless accelerated by HHSC	3 calendar days	$750 per document per HHSC request for information the MTO fails to have available on site for inspections.
MTO 34	Section 2.18.1	Demand Response Services The MTO must ensure that all demand response drivers do not charge program clients for services authorized by the MTO	100% of all Performing Provider services will be provided at no charge to clients. Upon being informed that a Performing Provider inappropriately charged a client, the MTO shall reimburse the client the charged amount within twenty-four (24) hours of being notified of the event.	As necessary	0 calendar days	$500 per incident, per day when the MTO does not reimburse the client within twenty-four (24) hours.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
MTO 35	Section 2.18.2	Client Communication The MTO will provide program services and information in the appropriate language and in adherence to the Limited English Proficiency (LEP) requirement.	100% of clients will receive services and information per LEP contract requirement.	Quarterly	0 calendar days	$1,000 for each time the MTO failed to adhere to the LEP contract requirement.
MTO 36	Section 2.18.3	Quality Assurance The MTO must adhere to the HHSC approved Quality Assurance Plan	100% compliance to all HHSC approved Quality Assurance Plan items	Continuous Monitoring	3 calendar days	$1,000 for each item in the HHSC approved Quality Assurance Plan for which the MTO is found non-compliant.
MTO 37	Section 2.18.3	MTO must prepare and submit an acceptable Quality Assurance Plan no later than forty-five (45) calendar days after the contract is awarded or by the date specified by HHSC.	Each calendar day after due date	One-time		$500 per day
MTO 38	Section 2.18.4	MTO must prepare and submit an acceptable Transition Plan to HHSC for acceptance and approval on the date set no later than forty-five (45) calendar days after the contract is awarded or upon a date approved by HHSC.	Within forty-five (45) calendar days after contract execution or by the date specified by HHSC.	One-time		$500 per day
MTO 39	Section 2.18.4	MTO must prepare and submit an acceptable Transition Plan no later than forty-five (45) calendar days after the contract is awarded	Each calendar day after due date	One-time		$500 per day

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		or by the date specified by HHSC.				
MTO 40	Section 2.20	MTO must prepare and submit an acceptable Comprehensive Work Plan no later than fourteen (14) business days after the contract execution.	Within fourteen (14) business days after contract execution or by the date specified by HHSC.	One-Time		$1,000 per day
MTO 41	Section 2.21	MTO must submit a final implementation work plan electronically or via mail no later than fourteen (14) business days after contract execution or by the date specified by HHSC.	Within fourteen (14) business days after contract execution or by the date specified by HHSC.	One-Time		$1,000 per day
MTO 42	Section 2.22.1.1	Payment Administration The MTO will promptly pay valid, undisputed Performing Provider invoices	98% of all undisputed Performing Provider invoices are paid within the terms of the agreement between the Performing Provider and the MTO. MTO will provide the documentation to support timely payment of Performing Provider.	Monthly unless accelerated by HHSC	0 calendar days	$1,000 per percentage point below 98% of all undisputed Performing Provider invoices in a calendar month when invoices are not paid according to the payment schedule agreed upon by the Performing Providers and approved by HHSC. MTO will provide the documentation to support timely payment of Performing Provider.
MTO 43	Section 2.22.2	MTO must perform monthly	Monthly	Ongoing		$100 per claim

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		validation checks of Performing Provider and/or Material Subcontract claims.				
MTO 44	Section 2.22.2	Report the required percentages in the format approved by HHSC for validation checks.	Failure to achieve and report the required percentages in the format approved by HHSC no later than thirty (30) days following payment of service	Ongoing		$100 per reporting period
MTO 45	Section 2.23.1	MTO must submit an Operational Readiness Plan no later than August 1, 2014.	Each calendar day after due date	One-Time		$5,000 per day
MTO 46	Section 2.23.2	Readiness Review The MTO must pass the Operational Readiness Review by the Required Timeframe	100% of all Readiness Review contract requirements are completed and approved by HHSC		MTO will have one opportunity to make corrections after the initial HHSC Operational testing. HHSC will provide date of second inspection.	$6,000 for each day following the second inspection date that the MTO is not fully operational with the option to terminate the contract award.
MTO 47	Section 2.23.3	MTO must submit a Financial Update Report to HHSC no later than sixty (60) days prior to the Operational Start Date.	Each calendar day after due date	One-Time		$5,000 per day
MTO 48	Section 2.24; 2.41	Records Management The MTO must comply with the approved HHSC recordkeeping and record retention policy.	100% compliance in meeting records management requirements. HHSC requests for documents	Quarterly unless accelerated by HHSC	3 calendar days	$5,000 for each occurrence when the MTO could not produce records referenced in the Recordkeeping and Record Retention section of

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
			must be received by the HHSC specified deadline.			the contract by the HHSC specified deadline. Occurrence means each HHSC request.
MTO 49	Section 2.24; 2.25	Reporting Requirements (excluding call centers, see additional Performance Measures document for call center reporting requirements) MTO must submit complete and accurate reports as outlined by the contract.	100% compliance in submitting complete and accurate reports according to the contract reporting requirements.	According to timeframes in Attachment J Contract Required Reports.	3 calendar days	$1,000 per report per business day that report is not accurate and complete. An accurate report contains responses which represent the truth to the best of the MTO's ability. A complete report contains responses to each item required in the report.
MTO 50	Section 2.24; 2.25	The MTO will file and submit all reports that require an immediate response according to the Reports Table.	100% of all MTO reports specified in the Reports Table that require an immediate response will be filed and submitted. "Immediate" is defined as being as soon as is reasonably possible, not to exceed three (3) hours from the time the MTO becomes aware of the triggering event.	As necessary	0 calendar days	$1,500 per incident that required an immediate response and was not reported timely.
MTO 51	Section 2.24; 2.25	Reporting Requirements (excluding call centers, see additional Performance Measures document for call center reporting requirements). The MTO must submit all required reports within the HHSC deadlines adhering to the Reports Table (Attachment J)	100% of all reports will be submitted within the required reporting timeframes.	According to timeframes in Attachment J Contract Required Reports unless accelerated by HHSC.	3 calendar days	$1,000 per report for each business day the report is not submitted after Cure Period.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
MTO 52	Section 2.26	Automation Systems The MTO must assure that automation and software systems required in the contract are operational.	100% compliance to maintain the required automation and software system operational.	Monthly unless accelerated by HHSC	0 calendar days	$1,000 for every increment of 60 minutes that automation and software system is not operational during normal reservation hours. Fractional periods of non-operation will be totaled during the normal reservation hours to calculate the increment."
MTO 53	Section 2.26	MTO must submit an annual certified financial audit through the close of each MTO fiscal year as required pursuant to Section 6.2.1.1 and 6.17.1.	Within the close of each MTO fiscal year just ended.	Annually		$1,000 per day
MTO 54	Section 2.27.2.5	MTO must prepare and submit an acceptable Disaster Recovery and Business Continuity Plan within ninety (90) days prior to the Operational Start Date or by the date specified by HHSC.	Each calendar day after due date	One-time		$200 per day
MTO 55	Section 2.27.2.5	MTO must prepare and submit an acceptable Security Plan no later than ninety (90) days prior to the Operational Start Date or by the date specified by HHSC.	Each business day after due date	One-time		$1,000 per day
MTO 56	Section 2.27.3	MTO must prepare and submit an acceptable Annual Disaster Recovery and Business Continuity Plan at the beginning of each State Fiscal Year.	Each calendar day after due date	Annually		$200 per day
MTO 57	Section	MTO must prepare and	Each calendar day after	Annually		$500 per day

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
	2.27.3.2.3	submit an annual acceptable Systems Quality Assurance Plan at the beginning of each State Fiscal Year.	due date			
MTO 58	Section 2.29.1.2	MTO must submit complete and accurate Encounter Data at least monthly.	Failure to submit complete and accurate Encounter Data at least monthly, but not later than the 30th calendar day after the last day of the month in which each claim was adjudicated.	Monthly		$500 per day
MTO 59	Section 2.35	Maintain all telecommunications related hardware and software, on an ongoing basis, that supports or impacts calls from or on behalf of a child birth through 20 with Medicaid, to support all requirements in §2.35.	No failure to telecommunications related hardware and software, during business hours.	Daily	n/a	$1,000 per failure to meet the requirements for all equipment, software, trunks, routing, etc. that impact call processing or handling for callers, from or on behalf of a child birth through 20 with Medicaid, to the Toll Free Client Line for transportation services. Liquidated damages will continually increase by $1,000 for each subsequent thirty minute period, after the initial five minutes of the outage until operations are fully restored. Liquidated damages will accrue only during the line's operational (business) hours. Any measureable amount of time over a minute (i.e., a second) will advance this

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						determination into the next minute (e.g., 5 minutes and 2 seconds will be treated as 6 minutes). Example: At 10:00 AM MTO staff spills coffee on a critical server which causes the MTO ACD reporting system to fail (with no redundant systems in place). If MTO systems are back on line within: • 5 minutes, the liquidated damages for this instance are $1,000. • 6 - 35 minutes, the liquidated damages for this instance are $2,000. • 36 - 65 minutes, the liquidated damages for this instance are $3,000. • 66 - 95 minutes, the liquidated damages for this instance are $4,000. • 96 - 105 minutes, the liquidated damages for this instance are $4,000, etc.
MTO 60	Section 2.35.3	The MTO's monthly report will include individual exam scores on new materials for MTO staff who answered calls, from or on behalf of a child birth through 20, with Medicaid for the prior month.	For staff answering calls, from or on behalf of a child birth through 20, with Medicaid, each individual must achieve a minimum score of 85% or better on all new	Each month in which staff answers calls, from or on behalf of a child birth through 20,	n/a	$500 for each occurrence. "Occurrence" is defined here as each new material exam score below 85% (the most recent exam on the topic) per staff who answered calls,

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		"New materials" include training for new staff or training of existing staff on new or updated materials. MTO staff who do not achieve the minimum required score for each exam on new materials, must not answer calls, from or on behalf of a child birth through 20, with Medicaid, until the required scores are achieved, via re-test. MTO must submit and certify the summary testing report to HHSC by the 2nd business day of the month following any month in which MTO staff answers calls, from or on behalf of a child birth through 20, with Medicaid. The monthly report must be submitted in a media and format approved by HHSC.	material exams.	with Medicaid.		from or on behalf of a child birth through 20, with Medicaid, during the month. It is not required that all MTO staff meet the 85% on the first try. Individuals failing to meet or exceed that minimum must not answer calls from or on behalf of a child birth through 20, with Medicaid until they are re-tested and able to achieve a score of 85% or better. Exam questions for staff being re-tested must be sufficiently different, to discourage memorization of the previous exam answers. Liquidated damages will continually increase by $250 (per exam, per staff) for each subsequent, consecutive month that non-compliance continues, for that particular MTO staff. Example: the MTO new hire training are comprised of 10 exams. MTO Agent A scores 85% or better on 8 of those exams and 70% on the remaining two exams. If MTO Agent A answers calls, from or on behalf of a child

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						birth through 20, with Medicaid, during the month, liquidated damages of $1,000 are due (two exam scores below 85%). However, if MTO Agent A re-takes the two exams in question and eventually achieves 85% or greater on both of them before answering calls , from or on behalf of a child birth through 20, with Medicaid, no liquidated damages are due for this measure for Agent A. "Re-test" is defined as a subsequent attempt to achieve the required score by an individual, on a test, per topic. Note that re-test is different from re-training (see definition of re-training below). The monthly summary testing report will indicate the MTO staff who answered calls, from or on behalf of a child birth through 20, with Medicaid, for the prior month and the most recent individual exam scores on new materials for these staff, for all topics.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						The submission of false or inaccurate information in reports will result in assessment of a liquidated damage of $20,000 and will entitle HHSC to terminate the agreement. HHSC will report suspected fraudulent reporting to appropriate enforcement authorities.
MTO 62	Section 2.35.3	The MTO's monthly report will include individual exam scores on re-training for MTO staff who answered calls from or on behalf of a child birth through 20 with Medicaid, for the prior month. "Re-training" shall include those staff, that call monitoring indicates a need for re-training. MTO staff who do not achieve the minimum required score for each re-training exam, must not answer calls, from or on behalf of a child birth through 20, with Medicaid, until the required scores are achieved, via re-test. MTO must submit and certify	Individual scores of 90% or better on all re-training exams, for staff who answer calls, from or on behalf of a child birth through 20, with Medicaid, each month.	Each month in which staff answers calls, from or on behalf of a child birth through 20, with Medicaid.	n/a	$500 for each occurrence. "Occurrence" is defined here as each re-training exam score below 90% (the most recent exam on the topic) per staff who answered calls, from or on behalf of a child birth through 20, with Medicaid, during the month. It is not required that all MTO staff meets the 90% on the first try. Individuals failing to meet or exceed that minimum must not answer calls, from or on behalf of a child birth through 20, with Medicaid, until they are re-tested and able to achieve a score of 90% or better. Exam questions for staff being re-tested must be sufficiently different, to

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		summary testing report to HHSC by the 2nd business day of the month following any month in which MTO staff answers calls, from or on behalf of a child birth through 20, with Medicaid. The monthly report must be submitted in a media and format approved by HHSC.				discourage memorization of the previous exam answers. Liquidated damages will continually increase by $250 (per exam, per staff) for each subsequent, consecutive month that non-compliance continues, for that particular MTO staff. Example: the MTO new hire training are comprised of 10 exams. Call monitoring of MTO Agent B indicates that re-training is required on one of these 10 areas. If MTO Agent B answers calls, from or on behalf of a child birth through 20, with Medicaid, during the month, after the determination that re-training is required, without have re-trained, taken the appropriate exam and achieved the required score, liquidated damages of $500 are due (one exam, no score yet as re-training has yet to occur). However, if MTO Agent B completes re-training and eventually achieves 90% or greater on the exam before answering calls, from or on behalf of a child birth through 20, with

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						Medicaid, no liquidated damages are due for this measure for Agent. The monthly summary testing report will indicate the MTO staff who answered calls, from or on behalf of a child birth through 20, with Medicaid, for the prior month and the most recent individual exam scores on re-training for these staff, for all topics. The submission of false or inaccurate information in reports will result in assessment of a liquidated damage of $20,000 and entitle HHSC to terminate the agreement. HHSC will report suspected fraudulent reporting to appropriate enforcement authorities.
MTO 63	Section 2.35.4	For calls determined to be placed by callers, from or on behalf of a child birth through 20, with Medicaid, during hours referenced in Section 2.3.10.1 the MTO will record all answered calls, from or on behalf of a child birth through 20, with Medicaid, in their entirety.	Record 100% of all calls placed from or on behalf of a child birth through 20, with Medicaid.	Monthly	n/a	$500 for each occurrence that violates the recording standard specified in §2.35.4 related to the client toll free line for transportation services, for those calls determined to be from or on behalf of a child birth through 20, with Medicaid. This amount is capped at $5,000 per day.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						"Occurrence" is defined here as each call, from or on behalf of a child birth through 20, with Medicaid, answered by a live Agent, that is either not completely recorded or where the recording is not produced upon request. Liquidated damages will continually increase by $250 per occurrence for each subsequent day in which there are additional occurrences. The amount only resets back to the original $500 per occurrence if the MTO has no violations of this standard for 3 consecutive months. <u>Example:</u> On Day 7, the MTO has an equipment failure that prevents 100 calls, from or on behalf of a child birth through 20, with Medicaid, from being recorded; liquidated damages for Day 7 are $5,000; $5,000 daily cap for this performance measure. Subsequently, on Day 16, MTO fails to record a single call, from or on

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						behalf of a child birth through 20, with Medicaid; liquidated damages for Day 16 are $750. The per occurrence damages are $750, based on Day 16 being a subsequent day in which there was an additional occurrence (without three consecutive months of compliance between them).Total liquidated damages for this month for this performance measure are $5,750. Subsequently, on Day 2 of the following month, MTO fails to record 4 calls, from or on behalf of a child birth through 20, with Medicaid; liquidated damages for Day 2 of this month are $4,000. The per occurrence damages are $1,000, based on the following progression: • $500 (1st occurrence was on Day 7 of the prior month), • $750 (2nd occurrence was on Day 16 of the prior month,), and • $1,000 (3rd occurrence was on Day 2 of the current month.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						• None of the three occurrences have three months of compliance between them. $1,000 times the four calls that were not recorded on Day 2 of the second month equals $4,000.
MTO 64	Section 2.35.4	Monitor and evaluate staff performance for calls from or on behalf of a child birth through 20, with Medicaid to the client toll-free line for transportation services. Calls must be submitted in a media and format approved by HHSC.	Monitor and evaluate 4% of calls from or on behalf of a child birth through 20, with Medicaid, as indicated on the summary quality activity report.	Monthly	n/a	$2,500 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $1,250 for each subsequent, consecutive month that non-compliance continues. "Occurrence" is defined here as each month in which the MTO does not monitor and evaluate a minimum of 4% of calls from or on behalf of a child birth through 20, with Medicaid on staff who answer calls from or on behalf of a child birth through 20, with Medicaid via the client toll-free line for transportation services, or staff that answer calls from or on behalf of a child birth through 20, with Medicaid that may be transferred, as part of the normal process flow, as

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						indicated on the summary quality activity report. Note: Rounding is limited to the nearest hundredth of one percent; at that point a number greater or equal to 4% must be the result in order to be considered compliant. The submission of false or inaccurate information in reports will result in assessment of a liquidated damage of $20,000 and entitle HHSC to terminate the agreement. HHSC will report suspected fraudulent reporting to appropriate enforcement authorities.
MTO 65	Section 2.35.4	Submit monitoring forms and monitored calls weekly for calls from or on behalf of a child birth through 20, with Medicaid (see Sections 2.3.10; 2.3.10.1) Reports must be submitted in a media and format approved by HHSC.	Submit weekly, as specified	Weekly	n/a	$500 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $250 for each subsequent, consecutive week that non-compliance continues. "Occurrence" is defined here as each week in which the MTO does not submit the monitoring forms and monitored calls from or on behalf of a child birth

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						through 20 with Medicaid, as required.
MTO 66	Section 2.35.4	Submit summary quality activity report monthly to HHSC (see Sections 2.3.10; 2.3.10.1; 2.35.12) Reports must be submitted in a media and format approved by HHSC.	Submit summary quality activity report monthly, as specified.	Monthly	n/a	$750 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $375 for each subsequent, consecutive month that non-compliance continues. "Occurrence" is defined here as each instance where the report is submitted past the specified due date. The submission of false or inaccurate information in reports will result in assessment of a liquidated damage of $20,000 and entitle HHSC to terminate the agreement. HHSC will report suspected fraudulent reporting to appropriate enforcement authorities.
MTO 67	Section 2.35.4	Customer service measures for calls from or on behalf of a child birth through 20, with Medicaid: • Staff are helpful and polite, irrespective of callers' telephone demeanor; • Staff interactions with	Maintain a monthly average score of 87% for customer service measures for all calls, from or on behalf of a child birth through 20 with Medicaid, monitored, as indicated on the summary quality activity report.	Monthly	n/a	$2,500 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $1,250 for each subsequent, consecutive month that non-compliance continues. "Occurrence" is defined here

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		callers demonstrate needs of HHSC clients; and • Staff are trained to deal with callers who are angry, threatening, or abusive.				as month when the average score of all customer service standards for calls from or on behalf of a child birth through 20 with Medicaid (as indicated by call monitoring sessions) drops below 87%. Example: The section(s) of MTO monitoring form for calls, from or on behalf of a child birth through 20, with Medicaid, that addresses the customer service measures for calls from or on behalf of a child birth through 20 with Medicaid will yield a score, that when averaged across all calls, from or on behalf of a child birth through 20, with Medicaid, monitored for the month, will meet or exceed 87%, in order to be compliant. Note: Depending on the design of the MTO monitoring form, this standard may be broken out into three separate standards, one for each component of the customer service standards for calls from or on behalf of a child birth through 20 with Medicaid,

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						or the MTO monitoring form may require other modification, which will be addressed during negotiations.
MTO 68	Section 2.35.4	Customer service measures for calls from or on behalf of a child birth through 20 with Medicaid: • Staff are helpful and polite, irrespective of callers' telephone demeanor; • Staff interactions with callers demonstrate needs of HHSC clients; and • Staff are trained to deal with callers who are angry, threatening, or abusive. When deficiencies in these standards are noted in call monitoring, they will be corrected (via coaching, counseling or re-training), within 30 calendar days.	Correct 100% of deficiencies in customer service standards within 30 calendar days, as indicated on the summary quality activity report.	Monthly	n/a	$250 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $125 for each subsequent, consecutive occurrence of non-compliance. "Occurrence" is defined here as each time a deficiency was noted, but not corrected within 30 calendar days and the agent continued to answer calls, from or on behalf of a child birth through 20, with Medicaid. Note that there could be multiple failures, per staff, resulting from a single monitoring session. Example: MTO Agent A is monitored on Day 14 of Month 1 and demonstrates three deficiencies in the customer service standards for calls from or on behalf of a child birth through 20 with Medicaid. MTO must coach, counsel or re-train (or

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						otherwise appropriately address these deficiencies) within 30 calendar days. If none of the deficiencies are addressed within 30 days, and Agent A continued to answer calls, from or on behalf of a child birth through 20, with Medicaid, the liquidated damages are $750 for Agent A for this measure, for the month. If another 30 days pass and only two of the deficiencies are addressed and Agent A continues to answer calls, from or on behalf of a child birth through 20, with Medicaid, the liquidated damages are $375 for Agent A for this measure, for that month ($250 plus $125). As the 30 day period to correct deficiencies may not always coincide with calendar months, MTO should include a section on the summary quality activity report, showing outstanding deficiencies where the 30 day period will carry forward into the next calendar month. Note: Depending on the

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						design of the MTO monitoring form, this standard may be broken out into three separate standards, one for each component of the customer service standards for calls from or on behalf of a child birth through 20 with Medicaid, or the MTO monitoring form may require other modification, which will be addressed during negotiations.
MTO 69	Section 2.36	The monthly average maximum wait (before answered by a live person), inclusive of all IVR time, for calls from or on behalf of a child birth through 20 with Medicaid. This measure is calculated as follows: 1. The MTO must track the length of the call that had the longest wait prior to speaking to a live person, each day. 2. The wait time includes all time spent in the IVR (or auto-attendant) as well as the time waiting in queue. 3. The length of each daily call with the longest wait,	Monthly average maximum wait of 300 seconds, or less, for calls from or on behalf of a child birth through 20 with Medicaid.	Monthly	n/a	$5,000 for the first month in which the average maximum wait times fail to meet the monthly standard specified in §2.36 related to the client toll free line for transportation services, for those calls determined to be from callers from or on behalf of a child birth through 20 with Medicaid. Liquidated damages will continually increase by $2,500 for each subsequent, consecutive month that non-compliance continues.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		prior to speaking to a live person for the month will be combined and divided by the total number of business days in the month. 4. The resulting number must not exceed 300 seconds.				
MTO 70	Section 2.37	The average monthly wait to speak to a live person after the IVR message and conclusion of user selection of menu items, for calls from or on behalf of a child birth through 20 with Medicaid. This measure is derived by dividing the total monthly time in queue for these calls (placed by callers, from or on behalf of a child birth through 20, with Medicaid), by the number of answered calls for the month (placed by callers, from or on behalf of a child birth through 20, with Medicaid), during the hours specified in §2.3.10.1.	Monthly average speed of answer to a live agent will not exceed 60 seconds, for calls from or on behalf of a child birth through 20 with Medicaid.	Monthly	n/a	$5,000 for the first month in which the average monthly wait to speak to a live person fails to meet the monthly standard specified in §2.35.12 related to the client toll free line for transportation services, for those calls determined to be from or on behalf of a child birth through 20 with Medicaid. Liquidated damages will continually increase by $2,500 for each subsequent, consecutive month that non-compliance continues.
MTO 71	Section 2.38	The number of calls that abandon, after conclusion of any IVR (or auto-attendant) selections, determined to be placed by callers, from or on behalf of a child birth through 20, with Medicaid, during hours referenced in §2.3.10.1	Monthly abandon rate will not exceed 10%, for calls from or on behalf of a child birth through 20 with Medicaid.	Monthly	n/a	$5,000 for the first month in which the MTO fails to meet the monthly standard specified in §2.35.12 related to the client toll free line for transportation services, for those calls determined to be from or on behalf of a child

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		This measure is determined as follows: The percentage of calls received from callers, from or on behalf of a child birth through 20, with Medicaid, during each month that are abandoned, after conclusion of any IVR (or auto-attendant) selections, determined to be placed by callers, from or on behalf of a child birth through 20, with Medicaid, during hours referenced in §2.3.10.1. The monthly total for this measure is divided into the monthly total calls received, after conclusion of any IVR (or auto-attendant) selections, determined to be placed by callers, from or on behalf of a child birth through 20, with Medicaid, during hours referenced in §2.3.10.1.				birth through 20 with Medicaid. Liquidated damages will continually increase by $2,500 for each subsequent, consecutive month that non-compliance continues.
MTO 72	Section 2.39	At the point where the call reaches the toll free line for transportation services, only 2% of calls can receive a busy signal, network error or any other type of response, other than being passed to a live operator, for calls determined to be placed by callers, from	Monthly percentage of blocked or failed calls at point where the call reaches the toll free line for transportation services, for calls from or on behalf of a child birth through 20 with Medicaid, will not exceed	Monthly	n/a	$5,000 for the first month in which the MTO fails to meet the monthly standard specified in §2.39 related to the client toll free line for transportation services, for those calls determined to be from or on behalf of a child birth through 20 with

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		or on behalf of a child birth through 20, with Medicaid, during hours referenced in §2.3.10.1 this standard applies. This measure is determined as follows: This standard applies from the point at which the call reaches the toll free number platform to the point at which the call is answered by a live operator. It applies to all calls determined to be placed by callers, from or on behalf of a child birth through 20, with Medicaid, during the hours referenced in §2.3.10.1. All call attempts during this time (determined to be placed by callers, from or on behalf of a child birth through 20, with Medicaid) are divided into the number of attempts that received a busy signal, network error or any other type of response, other than being passed to a live operator (determined to be placed by callers, from or on behalf of a child birth through 20, with Medicaid).	2%.			Medicaid. Liquidated damages will continually increase by $2,500 for each subsequent, consecutive month that non-compliance continues.
MTO 73	Section 2.40 2.35.12	For calls determined to be placed by callers, from or on	No call from or on behalf of a child birth through	Monthly	n/a	$1,000 for each occurrence that violates the standard

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		behalf of a child birth through 20, with Medicaid, during hours referenced in §2.3.10.1, staff (or equipment) are prohibited from answering a call and subsequently 1) asking callers to call back later, 2) informing caller that staff will contact them later, 3) disconnecting the call, or 4) taking some other similar action to shorten the call, short of scheduling the services requested.	20 with Medicaid can be answered by asking caller to: 1. call back later, 2. informing caller that staff cannot help them now, but that staff will contact them later, 3. disconnecting call, 4. taking other action to shorten call, other than scheduling requested services.			specified in §2.40 related to the client toll free line for transportation services, for those calls determined to be from or on behalf of a child birth through 20 with Medicaid. Liquidated damages will continually increase by $500 for each subsequent occurrence (either in the same monthly reporting period or in subsequent months). However, full compliance for three (3) consecutive months will reset the initial damage at $1,000. "Occurrence" is defined here as each instance where one of the items listed (items 1-4) occurs. If they are reported or subsequently discovered to occur 4 times in one day, that equals four occurrences. It is possible to have multiple occurrences per day.
MTO 74	Section 2.40.1	For calls determined to be placed by callers, from or on behalf of a child birth through 20, with Medicaid, during hours referenced in §2.3.10.1, staff failures to transfer calls	At no time can MTO staff fail to transfer callers, from or on behalf of a child birth through 20, with Medicaid, to THSteps, for scheduling	Monthly	n/a	$500 for each occurrence that violates the standard specified in §2.35.10 related to the client toll free line for transportation services, for those calls determined to be

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		to THSteps, as specified.	assistance when clients indicate that assistance is needed.			from or on behalf of a child birth through 20 with Medicaid. "Occurrence" is defined here as each instance where it is either reported or subsequently discovered that MTO staff failed to transfer calls to THSteps, when required, for call determined to be placed by a caller, from or on behalf of a child birth through 20, with Medicaid. This standard is limited to one instance per call. If these occur on four different calls in one day, that equals four occurrences. It is possible to have multiple occurrences per day. Liquidated damages will continually increase by $250 for each subsequent occurrence, in a single month.
MTO 75	Section 2.3.10; 2.35.2	The client toll-free line for transportation services will be answered by live operators continuously during the hours specified in §2.3.10.1 Monday through Friday (excluding approved holidays).	No down time in answering of client calls to the toll-free line for transportation services by MTO staff, during business hours.	Per occurrence	n/a	$10,000 per occurrence for failure to meet this requirement. Liquidated damages will continually increase by $5,000 for each subsequent consecutive occurrence. $500 per failure of live

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						operators to answer calls from all callers to the Toll Free Client Line for transportation services. Liquidated damages will continually increase by $500 for each subsequent thirty minute period, after the initial five minutes that calls are not answered until normal answering of calls resumes. Liquidated damages will accrue only during the line's operational (business) hours. Any measureable amount of time over a minute (i.e., a second) will advance this determination into the next minute (e.g., 5 minutes and 2 seconds will be treated as 6 minutes). Example: At 10:00 AM MTO staff are called out of their location for a fire drill, (with no redundant staff or alternate location in place). If MTO continues to answer calls within: • 5 minutes, the liquidated damages for this instance are $500. • 6 - 35 minutes, the liquidated damages for

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
						this instance are $1,000. • 36 - 65 minutes, the liquidated damages for this instance are $1,500. • 66 - 95 minutes, the liquidated damages for this instance are $2,000. • 96 - 105 minutes, the liquidated damages for this instance are $2,500, etc.
MTO 76	General Requirement: State Action Request	MTO must submit complete and accurate responses to any State Action Request (SAR) memos no later than the date specified in the request.	Each calendar day for each instance of late, unacceptable or no response.	Ongoing		$500 per day
MTO 77	General Requirement: State Action Request Extensions	MTO must submit written request for extension of a State Action Request (SAR) deadline that specifies the estimated date of completion and reasons for the extension no later than three (3) business days prior to the due date indicated in the SAR.	Each business day for each instance of late request for extension.	Ongoing		$500 per day
MTO 78	General Requirement: Failure to Perform an Administrative Service Contract	The MTO fails to timely perform an MTO Administrative Service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, such failure either: (1) results in	Each calendar day of non-compliance	Ongoing		HHSC may assess up to $7,500.00 per day for each incident of non-compliance.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
		actual harm to a Member or places a Member at risk of imminent harm, or (2) materially affects HHSC's ability to administer the Program(s).				
MTO 79	General Requirement: Failure to Provide a transportation service Contract	The MTO fails to timely provide a transportation service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, such failure results in actual harm to a Member or places a Member at risk of imminent harm.	Each calendar day of non-compliance	Ongoing		HHSC may assess up to $7,500.00 per day for each incident of non-compliance.
MTO 80	General Requirement:	The Parties agree that HHSC may assess a liquidated damage of up to $500 per calendar day for each instance of MTO's breach or nonperformance of a duty that is not specified in the Key Performance Requirements.	MTO must perform all duties required under the Contract.	Ongoing		$500 per calendar day for each instance of MTO's breach or nonperformance of a duty not specified in the Key Performance Requirements, after HHSC has given notice to MTO of such non-performance.

Reference Number	RFP Section	Performance Standard	Performance Measure	Monitoring Period	Cure Period	Liquidated Damage Value
MTO 81	General Requirement	The parties agree that HHSC may assess a liquidated damage of $1,000 per occurrence for any breach of contractual, regulatory, or statutory requirements not otherwise specified in the Key Performance Requirements.	MTO must perform all duties required under the Contract.	Ongoing		$1,000 per occurrence for any breach of contractual, regulatory, or statutory requirements not otherwise specified in the Key Performance Requirements.

AGREEMENT BETWEEN THE
TEXAS HEALTH AND HUMAN SERVICES COMMISSION
AND
LOGISTICARE SOLUTIONS, LLC

EXHIBIT L

The **Capitation Rates.**

FY2018 Final Rates - MTO Region 10.xlsx

Medical Transportation Program
FY2018 Final Rates

Region Name		Adults		Children		
		Urban	Rural	Urban	Rural	CSHCN
MTO - Region 10	MTO 10	8.27	15.38	1.68	1.97	1.68